

R E M

|
Restore

|
Empower

|
Mobilize

**Psychotherapy for treating depression
in long-term care residents with dementia**

Brian Carpenter, Ph.D.
Department of Psychology
Washington University in St. Louis

Katy Ruckdeschel, Ph.D.
Department of Geriatric Psychiatry
University of Pennsylvania

Holly Ruckdeschel, Ph.D.
Transitional Care and Rehabilitation
Coatesville Veterans Affairs
Medical Center

Kimberly Van Haitzma, Ph.D.
Polisher Research Institute
Madlyn and Leonard Abramson Center
for Jewish Life

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Preface

The practice of psychotherapy has a long history, but only recently has psychotherapy with older adults achieved more widespread application. Still rare are psychotherapeutic approaches for working with older adults who have dementia (for a review see Kasl-Godley & Gatz, 2000).

In this manual we present a psychotherapeutic treatment called REM, which stands for the phases of treatment, Restore, Empower, and Mobilize. REM is a treatment for depression that is designed to be used with older adults who have dementia and who live in a long-term care residence. In this first chapter we provide some details about how the manual is organized and conventions that we use throughout the manual.

Organization of the manual

Below is a description of each chapter in the manual. Depending on your degree of familiarity with older adults, with dementia, and with long-term care settings, some chapters may cover content that is entirely new to you. Other chapters may simply review information with which you are already familiar. We advise you to read the entire manual, but you may wish to pay particular attention to certain chapters, depending on your background. The descriptions below may guide you in determining which chapters will be most useful given your experience.

- Key chapters for readers who have little experience with older adults:

Chapter 2 – An Overview of REM Psychotherapy

Chapter 3 – Clinical Considerations

- Key chapters for readers who have little experience with dementia:

Chapter 2 – An Overview of REM Psychotherapy

Chapter 3 – Clinical Considerations

- Key chapters for readers who have little experience with in long-term care settings:

Chapter 3 – Clinical Considerations

Chapter 4 – The Importance of a Systems Perceptive

Regardless of your background, we recommend that all clinicians read Chapters 5-10 in their entirety. The therapeutic work in REM is cumulative, meaning that much of what you do late in the course of therapy builds on what you did earlier. Similarly, some

things that will become important later in the therapy will need your attention up front, perhaps even before your first session. Reading the entire manual before starting the treatment will prepare you for the key issues.

Chapter	Contents
Chapter 1..... Introduction	Information about who the treatment is for, using a treatment manual, and the empirical validation of REM psychotherapy.
Chapter 2..... An Overview of REM Psychotherapy	An introduction to the theory and practice of REM psychotherapy; includes a discussion of the etiology of depression, an introduction to the three phases of REM, suggestions about the mechanics of therapy such as frequency and duration, and a brief list of useful assessment tools.
Chapter 3..... Clinical Considerations	A discussion of topics that influence the process of therapy with older adults in the context of long-term care, including characteristics of older adults, therapists, family members of residents, and the long-term care environment. This chapter is especially important for clinicians who have little experience with older adults, dementia, or long-term care settings.
Chapter 4..... Systems Perspective	REM treatment relies on a systems approach to therapy, involving not only the resident but also the wider social and environmental context in which the resident lives. This chapter addresses issues related to interfacing with long-term care staff, understanding the influence of the policies and philosophy of the institution, and enlisting family members in the treatment process when appropriate.
Chapter 5..... Establishing a Treatment Plan	A review of the process of establishing a treatment plan, including when to develop one, who contributes to it, and what good treatment goals look like; includes examples of treatment plans and suggestions about how to monitor treatment progress and outcome.
Chapter 6..... The First Session	Details about educating and orienting the resident to psychotherapy, instilling positive expectations for therapeutic success, and building rapport with the resident.
Chapter 7..... Restore	Details on the first phase of treatment; developing a good therapeutic relationship, acknowledging the resident's experience, and restoring a positive sense of self.

Chapter	Contents
Chapter 8..... Empower	Details on the second phase of treatment; enhancing perceptions of personal competence and control, and encouraging adaptive coping skills.
Chapter 9..... Mobilize	Details on the third and final phase of treatment; activating the resident to make positive changes and activating the resident's environment (i.e., family, staff, and beyond) to promote and sustain positive mental health.
Chapter 10..... Termination	Considerations for determining when the resident is ready to end therapy and preparing for the final session, content of the final session, and follow-up.

Writing conventions throughout the manual

We have tried to use gender-neutral language when possible. On occasion we use "he" or "she" in reference to a hypothetical resident or therapist because it enhances the tone of the writing and, we hope, enables readers to imagine an actual resident with whom they might work. Our own attempt to balance gender-sensitive language with a readable style led us to this compromise: in a particular chapter we use one gender throughout, but we alternate gender from chapter to chapter. For instance, all examples in Chapter 2 refer to female residents, while all examples in Chapter 3 refer to male residents.

We describe REM as a treatment that can be used with older adults in "long-term care" settings. When we use that term we are referring to nursing homes, assisted-living facilities, and other supervised, institutional environments for seniors. Some of the principles in REM therapy may be relevant to older adults in other settings, but certain aspects of the treatment are specific to these more sheltered living environments.

We also describe REM as a treatment for depression with older adults who have dementia. It is perhaps more accurate to say that the treatment is designed for older adults with "cognitive impairment." It is the pattern of cognitive and behavioral deficits that influence the process of psychotherapy rather than a specific psychiatric or neurological diagnosis. Still, on occasion we use dementia as shorthand to refer to residents with impairment in memory, attention, concentration, reasoning, judgment, and other cognitive functions. Naturally, impairments in those functions can be due to many different factors, such as Alzheimer's disease, vascular disease, head trauma, HIV, Parkinson's disease, Huntington's disease, Pick's disease, chronic alcohol use, or other medical conditions. Again, we are less concerned with the specific diagnosis and more with its impact on the resident and its implications for how psychotherapy needs to be adapted.

Finally, when we refer to the direct care staff who work in long-term care residences, we use the term Certified Nursing Assistant (CNA). In some residences these people are also known as Resident Care Assistants, Health Aides, or Health Care Aides. We mean the staff who provide the bulk of the hands-on care to residents and, as such, the staff who play such a critical role in creating a nurturing living environment.

Acknowledgments and contact information

Financial support for the initial development of the treatment manual and a preliminary evaluation of the treatment was provided by a grant from the National Institutes of Mental Health (NIMH 5-P30-MH52129, Dr. Ira Katz) and the Harry Stern Family Center for Innovations in Alzheimer's Care at the Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life (formerly known as the Philadelphia Geriatric Center). Support for the revision of the manual and its distribution was provided by a grant from the Veteran's Administration VISN 4 Mental Illness Research, Education, and Clinical Center (MIRECC).

The skilled clinicians who assisted with the development of the treatment manual and initial pilot testing included David Allen, Loren Connolly, Phyllis DeCuollo, David Funk, Michele Gagnon, Steven Levine, Kathy O'Leary, David Payne, Sarah Stookey, and Jay Weissman.

Additional information about REM treatment, including efforts to evaluate its effectiveness, can be obtained from any of the four authors listed below.

Brian Carpenter, Ph.D.
Assistant Professor
Department of Psychology
Campus Box 1125
Washington University
St. Louis, MO 63130
(314) 935-8212
bcarpenter@wustl.edu

Katy Ruckdeschel, Ph.D.
Assistant Professor
University of Pennsylvania
Philadelphia VA Medical Center/116A
University & Woodland Avenues
Philadelphia, PA 19104
(215) 823-5957
ruckdesc@mail.med.upenn.edu

Holly Ruckdeschel, Ph.D.
Coatesville VA Medical Center
Transitional Care and Rehabilitation
(138B)
1400 Black Horse Hill Road
Coatesville, PA 19320-2096
(610) 384-7711 ext. 4114
holly.ruckdeschel@med.va.gov

Kimberly Van Haitsma, Ph.D.
Associate Director
Polisher Research Institute
Madlyn and Leonard Abramson Center
for Jewish Life
1425 Horsham Road
North Wales, PA 19454-1320
(215) 371-1895
KVanHaitsma@abramsoncenter.org

Chapter I ~ Introduction

This manual describes a model of psychotherapy that can be used with long-term care residents who experience depression and dementia. The therapy is called REM, an acronym that stands for the three phases of treatment, Restore, Empower, and Mobilize. Each phase focuses on a different strategy for restoring positive mood and maintaining adaptive functioning.

Some aspects of psychotherapy have to be handled differently when you are working with individuals who have problems with their memory and other facets of cognition. The REM treatment model takes into account the complexity of working with clients who have significant—and perhaps progressive—cognitive impairment. The treatment model also acknowledges the challenges of working in residential care settings. REM tries to maximize the unique resources of those settings and minimize the limitations.

Who is this treatment for?

- Older adults living in long-term care or other institutional settings.

Long-term care settings are environments that have the potential to enhance or to jeopardize the psychological well-being of older adults. REM interventions help older adults cope with the challenges of living in care settings where they may experience diminished autonomy while receiving a great deal of assistance and supervision. Some portions of REM treatment are applicable to depression in older adults regardless of where they live. As a whole, however, the treatment is designed specifically for older adults in nursing homes or assisted living facilities.

- Older adults who have mild to moderate cognitive impairment.

REM treatment recognizes the role that cognitive impairment can play in the development and exacerbation of depression (and vice versa). REM also acknowledges that cognitive impairment poses a challenge to traditional "talk" psychotherapies. For instance, memory limitations may interfere with a resident's ability to recall information from session to session, and language impairments may necessitate changes in word choice and pacing. In this manual we include suggestions about how to structure the treatment to accommodate those cognitive changes.

In our experience, individuals with mild to moderate cognitive impairment can reasonably participate in this treatment. Some preserved ability to learn and remember is necessary. Perhaps more important, however, is an ability to engage with a therapist in meaningful conversation. As a rough guide, patients with Mini-Mental State

Examination (MMSE; Folstein, Folstein, & McHugh, 1975) scores ranging from 15 to 30 are appropriate, although we have used the treatment with residents who score as low as 10 on the MMSE. Because of the great variability in presentation among individuals with dementia, clinicians will need to make the ultimate judgment about whether a particular resident may benefit from this treatment. REM therapeutic activities then can be adapted to match the cognitive skills of the resident.

- Older adults who are depressed.

We have used this treatment to address a range of disorders in the depression spectrum, including Major Depression, Adjustment Disorder with Depressed Mood, and Dysthymia. REM treatment is likely to be less effective with residents who have a comorbid thought disorder or other severe psychiatric symptoms that are more pressing than their depression or that would interfere with treatment.

Who is this treatment NOT for?

Residents who have depression with psychotic features and residents with severe forms of dementia are not likely to benefit from this treatment. Residents who are actively suicidal are likely to need a level of intervention that is more structured and intensive than this therapy alone provides.

Who is the manual for?

REM therapy is designed to be administered by mental health professionals who have a solid knowledge of personality, psychopathology, and psychotherapeutic interventions. Psychologists, social workers, psychiatrists, and psychiatric nurses are likely to have the requisite knowledge and experience to be able to conduct the treatment. The treatment is not intended to be administered by paraprofessionals, family members, or others who have little training in the delivery of psychotherapy.

Why use a treatment manual?

Treatment manuals are becoming more and more common in the delivery of psychotherapy. First, they provide an efficient way to share knowledge about successful types of treatment. Second, they help clinicians define treatment goals and remain focused on those goals throughout therapy. Third, treatment manuals allow researchers to standardize treatments and replicate them so their efficacy and effectiveness can be tested. Rigorous empirical validation of psychotherapeutic treatments can only be accomplished with an organized, replicable treatment regimen, and treatment manuals

help provide that structure.

Some therapists may be unfamiliar with using a treatment manual to guide psychotherapy. For instance, there may be concerns about whether a treatment manual will be overly rigid and will interfere with the ability to tailor sessions and interventions to the needs of a client. On the contrary, REM therapy offers an opportunity for—and in fact encourages—individualization of treatment goals and strategies. Yet it does so within a particular theoretical framework.

The framework for REM treatment has emerged from two sources. The first is theory and practice concepts from other mental health researchers and practitioners. REM treatment benefits from the collective wisdom of many other psychotherapeutic approaches, including cognitive-behavioral, humanistic, psychodynamic, interpersonal, and systems perspectives. In its conceptualization of psychopathology and its use of certain intervention strategies, REM borrows useful elements from other traditions and combines them in a way that suits the long-term care population. The second source of information for REM is psychologists' many years of experience working with older nursing home residents at the Philadelphia Geriatric Center (now known as the Abramson Center for Jewish Life). Over time, those therapists have had the chance to observe how depression emerges, how it plays out in long-term care residents with dementia, and what interventions may be useful for its amelioration. This treatment manual distills the observations of those clinicians and the theoretical concepts of other psychotherapy approaches.

You will notice that the treatment manual does not include a step-by-step, or session-by-session outline of what you should say or when you should say it. Instead, the manual introduces the REM model of therapy and then suggests techniques and areas of focus that may be helpful with certain residents at certain times. REM offers a standardized way of approaching the treatment of depression in long-term care residents with dementia, but it also allows you to focus on goals and techniques that are particularly suited to your clients.

Empirical support for this treatment

To date, REM has been tested with only a circumscribed group of patients. Preliminary research was conducted with nursing home residents who were over age 65, and were experiencing a DSM-IV depressive disorder (Major Depressive Disorder, Adjustment Disorder with Depressed Mood, or Depression NOS) and a comorbid mild–moderate dementing illness (Alzheimer's Disease, Vascular Dementia, or a dementia of mixed etiology). The preliminary research suggested that 1) therapists can learn and apply REM treatment principles successfully, 2) residents can engage in the therapy and participate in the treatment process, and 3) ancillary people (e.g., staff and family members) can be enlisted in the treatment process. Some evaluative data also suggest that the treatment can be helpful in addressing depressive symptoms. A brief description of the treatment model and some of the preliminary outcome data appear in

Carpenter, Ruckdeschel, Ruckdeschel, & Van Haitsma (2002).

Despite these promising beginnings, readers should be aware that, at this point in time (November, 2003), REM therapy is a treatment model that has not been rigorously tested in empirical studies. Additional research is in progress, and details about the current status of the treatment can be obtained from the authors. Contact information appears in the Preface.

Chapter 2 ~ An Overview of REM Psychotherapy

REM psychotherapy is designed to treat long-term care residents who experience some degree of cognitive impairment as well as depression. The psychotherapy emerges from the belief that there are unique factors that coalesce in this group of individuals that demand a specialized approach to psychotherapy. These factors include issues related to growing old, living in a long-term care residence, experiencing cognitive impairment, and experiencing depression.

As a group, these factors can have a devastating cumulative effect on an older adult. Moreover, together these factors pose challenges to traditional psychotherapeutic approaches. Successful psychotherapy with older adults requires incorporating modifications that acknowledge the unique background and needs of older adults. The type or style of psychotherapy a therapist uses with younger clients may not be as successful with older clients. When conducting psychotherapy with *long-term care residents*, in particular, one needs to be sensitive to the possibilities and limitations for individuals who live in a structured, institutional setting where the fulfillment of many of their needs depends on other people.

Consider a couple examples. When a younger client talks to her therapist about being dissatisfied with a relationship, a focus of treatment may be talking about ways to confront the individual with whom there is tension. However, a resident in a long-term care residence who experiences a difficult relationship with a staff member may be reluctant to talk directly with the staff member, fearing reprisals from this person on whom she is dependent. As another example, therapists who work with younger individuals may reasonably assume the client's ability to remember the content of sessions from week to week. Older adults with cognitive impairment, on the other hand, may not recall specific details about previous sessions, though they may retain the general themes discussed. Therefore, in conducting psychotherapy with individuals who suffer from dementia, one needs to accommodate possible limitations in memory, attention, concentration, and judgment.

A model of depression

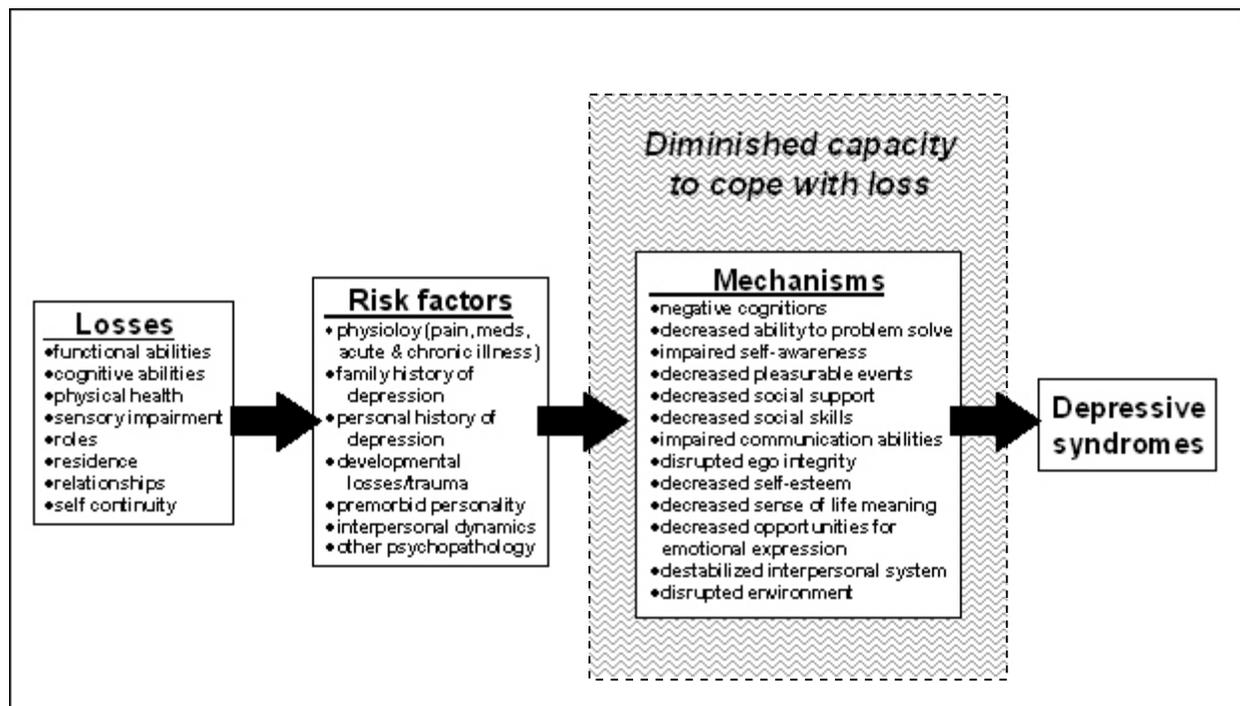
Here we present a brief summary of the theoretical principles underlying REM treatment (see the model in Figure 1). This model of depression is an amalgam of ideas that incorporates a wide variety of perspectives—biological, interpersonal, cognitive, behavioral, and humanistic, to name a few. Our goal is not to propose a new theory of depression but rather to describe our understanding of the factors that may contribute to the development and maintenance (and eventual amelioration) of depression among long-term care residents with dementia.

The first question is, Why does depression occur in this group of people? Of course the reasons are complex, but in general, older adults who live in a long-term care

residence and who cope with dementia are faced with a number of challenges:

- long-term care settings generally impose a forced structure and reinforce dependency (Baltes, 1988);
- separation from family and friends makes some individuals feel despondent about their position in life and their prospects for the future;
- physical disability can limit mobility and independence;
- dementia, with its deterioration in basic mental functions, can make it difficult to perform daily tasks and engage in meaningful social interaction.

Figure 1. The context of depression and dementia in long-term care settings.



These challenges represent significant losses, which can influence how residents feel about themselves. In more abstract terms, they represent insults to the “self,” or one’s sense of personal identity. These multiple losses can accumulate and, in some cases, lead to depression.

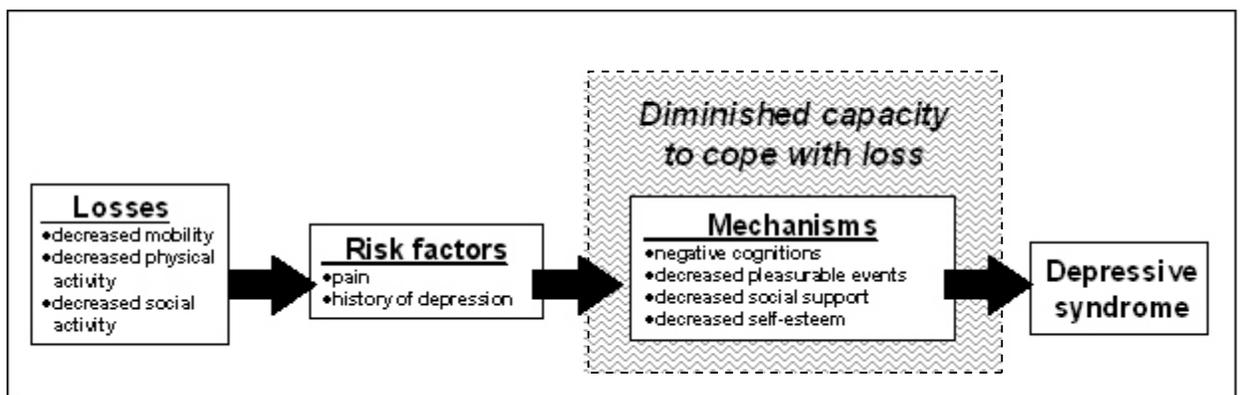
While many older adults experience losses, not all of them develop depression. Some individuals may be more vulnerable to depression as a result of risk factors. For instance, if an individual has a family history of depression or has been depressed in the past, she may be more likely to develop depression in the long-term care residence. In general, the more risk factors an individual has, the greater her vulnerability.

How do losses and risk factors combine to make a person depressed? In Figure 1 we list the numerous mechanisms that can link losses and risk factors to depressive syndromes. As an oversimplified example, consider the following:

Mrs. Clarke was depressed a few years ago, and now staff are concerned that she may be becoming depressed again. She suffers from chronic arthritis in her legs, and her pain and discomfort are growing worse. The arthritis limits her ability to walk, and she needs assistance to attend social activities in the nursing home. Because of her pain, she also has more difficulty leaving the nursing home when her family wants to take her out. Consequently, Mrs. Clarke has been spending more and more time in her room. She is discouraged by what she describes as the “betrayal” by her body. She is frustrated about not being able to keep up her social contacts, and she anticipates that the problem will only get worse. Although previously Mrs. Clarke was able to motivate herself to stay active and cheer herself up, she seems less able to do so now that mild cognitive impairments have emerged. The nursing home staff and her family have noticed that Mrs. Clarke has become increasingly pessimistic and withdrawn, hopeless that she will ever feel competent or joyful again.

Figure 2 shows how Mrs. Clarke’s situation fits the REM model for the development of depression. She has experienced a number of losses (mobility, social connectedness) that interact with risk factors (pain, a history of depression). These evoke depressogenic mechanisms (negative cognitions, decreased self-esteem) that lead to a depressive syndrome. In addition, Mrs. Clarke’s cognitive impairment limits her ability to use adaptive coping strategies that have been helpful to her in the past. This is a simplified example, but it demonstrates the cascade of factors that can contribute to the development of depression in the context of dementia.

Figure 2. An example of the emergence of depression.



As demonstrated by Mrs. Clarke's case, the effects of risk factors, losses, and mechanisms interact with a resident's cognitive status. Residents whose cognitive skills are fully intact may be able to exert greater control over their thoughts, emotions, and behavior. Residents whose cognitive skills are beginning to decline, on the other hand, may have a more difficult time thinking clearly about the losses they experience, modulating emotional responses to losses, and marshaling resources in an attempt to cope with losses. Consequently, risk factors may be more salient, losses more poignant, and mechanisms more potent in individuals whose thinking is impaired.

REM therapy attempts to address the factors contributing to depression by restoring a resident's sense of self, empowering her to live to her potential, and mobilizing her and the environment around her. This therapy is integrative, borrowing from techniques and strategies that have been used successfully in a wide variety of other treatments. In this sense, some aspects of REM treatment will sound familiar to clinicians schooled in other psychotherapeutic approaches. What is unique about REM treatment, however, is that it applies these strategies in a way that recognizes the unique needs of an individual who is living in a long-term care residence and experiencing dementia. The therapy consists of three phases of treatment.

RESTORE This phase of treatment aims to revive the resident's sense of self. Interventions focus on developing a therapeutic relationship, providing empathic acknowledgment of the resident's experience, restoring a sense of self-worth and meaning, and instilling hope.

EMPOWER The goals in this phase of treatment are to enhance the resident's perception of personal competence and control and to promote adaptive coping skills. This problem-solving phase involves emphasizing strengths, reviewing past coping successes, and planning for ways to improve the resident's current situation.

MOBILIZE In this phase the restoration and empowerment from the previous phases are put into action. The resident is encouraged to make changes that will improve her circumstances and mood. Interventions with family, peers, and long-term care staff often are required. Procedures and practices are enacted to help maintain treatment gains. Preparations are made for the eventuality that the resident with dementia may need increasing assistance in detecting and managing future episodes of depression.

Although REM treatment is structured in three phases, and although we conceive of the phases sequentially, in reality they overlap. For example, your work to establish and maintain a therapeutic relationship and bolster the resident's sense of self will start in the Restore phase but continue throughout treatment. You'll likely spend a greater proportion of your time on Restore interventions early in the treatment, but some of

those elements are likely to appear in all sessions. Similarly, although Mobilize strategies are likely to be the focus later in the therapy, in order to mobilize the resident's environment you will need to start making assessments of that environment early in the therapy.

Mechanics of the therapy

- **Number of sessions**

In designing this treatment we tried to bear in mind the practical limitations that may be imposed as a function of ever-changing reimbursement policies. More and more, clinicians are under pressure to utilize short-term treatment models. Additionally, in order to evaluate this therapy systematically, we needed to specify a treatment time frame to establish some uniformity across cases. On the basis of our preliminary findings, we estimate that approximately 16 sessions is a good guide for how many sessions to plan. Rather than dictate a specific number of sessions, we advise that you rely on your clinical judgment about what best suits each resident.

Some residents progress through the REM phases quickly and may be improved and ready for discharge after 12 sessions; others progress more slowly and may require more than 20 sessions. It is not unusual for the resident to experience additional losses during the course of treatment, which could extend the number of sessions required to meet your treatment goals. Again, clinical judgment best guides the duration of treatment. Subsequent chapters in this manual address goal setting and termination issues in more detail, and may be helpful in determining how many sessions will be necessary for a specific resident.

- **Duration of sessions**

Therapy sessions that last 20-30 minutes seem best suited to this population. Shorter sessions accommodate limitations in attention and concentration that often accompany dementia and depression. Older adults also may become fatigued with longer sessions.

- **Frequency of sessions**

The typically frail nature of this patient group and their common limitations in memory and concentration are factors that favor shorter, more frequent sessions. We recommend two short sessions per week. A Monday–Thursday or Tuesday–Friday schedule provides a good distribution of contact. We had initial concerns that reimbursement organizations would question the medical necessity of two appointments per week. In our experience this was not a problem, but this will vary according to the policies and practices of individual insurance carriers. Finally, with some residents you might taper sessions to one meeting per week in order to prepare for discharge.

- Location of sessions

Therapy sessions should be conducted in a quiet, private place free from distractions. Patients who have impairments in memory and concentration benefit from environments with few competing stimuli. Meeting the resident in the same place for each session can help reinforce the nature of your meetings. A private office with a closed door is ideal. In reality, it may be difficult to find a place in the long-term care residence that is entirely private, particularly if a therapist is only a consultant at the residence. When it is necessary to meet with residents outside of an office setting (e.g., in the resident's room or in some common space) therapists will need to remain sensitive to the need for confidentiality.

Structure of the therapy

The three phases of REM treatment offer different strategies and address different goals to help residents overcome depression and regain optimum functioning. As mentioned earlier, the progression of REM phases and the focus of specific sessions will vary from resident to resident. Nonetheless, you and the resident should be able to determine a set of therapeutic goals no later than the end of the third session. Those three initial sessions should give you adequate opportunity to gather historical information, assess the resident's strengths and weaknesses, and prioritize the issues most salient to the resident. With this information you and the resident are ready to plan treatment goals.

Below are three examples of the number of sessions you might spend in each phase of treatment. Each example includes a brief case description and examples of how the course of therapy was modified to suit the needs of the resident. You may need to spend more or less time on each phase depending on the needs of each particular resident. Again, in actual practice the phases will overlap.

Three alternative structures for treatment

Case A: Example of a “typical” client

Course of treatment	Session 1 Introduction Sessions 2-6 Restore Sessions 7-10 Empower Sessions 11-15 Mobilize Session 16 Termination
Rationale	Mrs. A presents with moderate depression (Geriatric Depression Scale [GDS] score = 16), some vegetative symptoms, social withdrawal, and feelings of worthlessness. Her mild cognitive impairment (MMSE=22) includes problems with memory, concentration, and attention. In Session 1 the therapist provides basic education and orientation about depression and psychotherapy. The five Restore sessions are used to gather historical information relevant to restoring a sense of positive personal identity. They are also used to explore current circumstances and dissatisfactions. Four Empower sessions are used to identify things about her life that Mrs. A would like to change. She has intact insight and reasoning and is able to participate actively in identifying useful modifications to her routine and interpersonal relationships. In the five Mobilize sessions Mrs. A and her therapist enlist staff to help with environmental and activity modifications. The final session is used to review treatment gains and discuss relapse prevention.

Case B: Client with extreme deterioration in sense of self

Course of treatment	Session 1 Introduction
	Sessions 2-9 Restore
	Sessions 10-13 Empower
	Sessions 14-15 Mobilize
	Session 16 Termination

Rationale

Mrs. B presents with severe depression (GDS=25) and deep feelings of worthlessness, guilt, hopelessness, and a passive wish to die. Self-deprecating comments are common and intractable, and Mrs. B expresses feelings of utter helplessness and demonstrates extreme passivity. Mild cognitive impairment (MMSE=21) enables her to engage in therapy sessions but recall of content is somewhat impaired, and her motivation is low. In the first session the therapist provides, basic education and orientation about depression and psychotherapy. Eight Restore sessions are needed to bolster self-esteem and decrease the degree of self-criticism. Four Empower sessions occur during which Mrs. B is encouraged to discuss her previous coping successes and to strategize about ways to improve her life. Only two Mobilize sessions are required, as Mrs. B is capable of initiating environmental changes and increased activity on her own. The final session is used to review treatment gains and discuss relapse prevention.

Case C: Client with significant cognitive impairment

Course of treatment	Session 1 Introduction Sessions 2-7 Restore Sessions 8-9 Empower Sessions 10-15 Mobilize Session 16 Termination
Rationale	Mrs. C presents with mild depression (GDS = 11) and moderate cognitive impairment (MMSE = 17). She can recall having met the therapist from week to week but has no apparent memory of session content from previous weeks. In the first session the therapist provides basic education and orientation about depression and psychotherapy. The six Restore sessions are used to reestablish continuity with past roles. A memory book and journal are started. The Empower phase is relatively short in this treatment because of cognitive limitations. Greater time is spent in the Mobilize phase, with six sessions spent, in part, educating family members about how to recognize and respond to depressive and behavioral symptoms. Staff training is incorporated, and formal mechanisms are put into place to ensure the resident is involved in activities and routines that have been identified as enjoyable and meaningful to her. The final session is used to reaffirm the positive affective experience of therapy and to discuss the end of the therapeutic relationship.

Assessments

In addition to a thorough clinical interview and discussions with staff and family members, you may use objective instruments to help you determine the resident's level of symptomatology and functioning at the beginning, during the course, and at the conclusion of therapy. Many instruments have been designed and validated with older individuals, some with depressed and demented older individuals. A more extensive discussion of assessment issues in dementia and depression can be found in Storandt & VandenBos (1994), La Rue (1992), and Lichtenberg, (1999).

For a sample of instruments you may find helpful as initial assessments and when tracking the progress of therapy, see the section, "Assessing progress toward treatment goals" in Chapter 5, *Establishing a Treatment Plan*.

Chapter 3 ~ Clinical Considerations

In this section we describe a variety of factors that may have an impact on your therapeutic work. Working with older adults in a residential setting can be a rewarding and successful experience, but there are times when you'll face challenges that you aren't likely to encounter in other settings. Being able to anticipate and prepare for those challenges will help you navigate them with success.

Therapists who have experience with older adults, with cognitive impairment, and with institutional settings may simply need to skim this section. Otherwise we recommend a thorough review of the issues here. We outline important clinical considerations at four levels:

- ❶ aspects of the client
- ❷ aspects of you, the therapist
- ❸ aspects of the client's family
- ❹ aspects of the institutional setting.

Throughout this section we have framed these issues as questions you might ask yourself before you begin treatment.

❶ Aspects of the client

- What is the cognitive status of your client?

One of the most important elements in being an effective therapist with long-term care residents is having a thorough knowledge of their current cognitive functioning. For treatment to be successful, you need to be mindful of the impact of dementia on memory, attention, expressive and receptive language, and executive functions such as planning and judgment. You also need to consider how the goals, strategies, and scope of treatment of persons with dementia need to be modified. Treatment goals may be pragmatic as well as psychologically enriching, strategies more active and direct, and the scope broader to incorporate the larger long-term care system.

If you have not performed a cognitive evaluation yourself, check the resident's chart for a neuropsychological report or other evaluation that has focused on cognitive status. If that information is not available or is outdated, you might consider requesting that an updated evaluation be performed. At the very least you'll want to keep the following aspects of cognitive functioning in mind because all can influence your therapeutic work.

Memory – determines the resident’s ability to remember when his appointments are, details about you (your name or even who you are and why you visit him), details about previous sessions, goals that you have set, and his activity between sessions. Repetition and reinforcement are important strategies to compensate for memory impairment. Writing things down for the resident is another useful technique, in the form of lists, charts, workbooks, or memory books.

Attention – influences the resident’s ability to focus on your questions, his answers, and his internal state. Residents with poor attention may be distracted by competing stimuli in the environment or by their own thoughts during your sessions. Prompting the resident, reorienting him to what you are talking about, minimizing distractions, and using short sessions are useful strategies.

Language – determines the resident’s ability to express himself and understand you. In terms of expressive language abilities, a resident may have difficulty locating words or constructing grammatically coherent sentences. His speech may seem convoluted or nonsensical at times. You may need to “decode” what he is saying. Gentle prompting and cuing is helpful at times, although not when it further frustrates the resident or stems from your own impatience. Also keep in mind that a resident may use some words that are unfamiliar to you because of cohort differences. For instance, a “speak-easy” (bar), a “dough boy” (soldier), and a “jersey” (shirt) may be familiar to him but not to you. Similarly, a resident may be an immigrant for whom English is not a first language.

In terms of receptive language abilities, a resident may take more time to process what you are saying. You may need to decrease the pace of your speech and give the resident more time to think about what you have said and prepare his response. You may experience prolonged silences in your sessions as a resident considers what you have said and what he wants to say in return. Repetition, rewording, and paraphrasing can help. It is also helpful to ask residents to repeat things that have been agreed upon (e.g., session plans, treatment goals, homework assignments) to make sure he understands things as you do.

Planning, reasoning, and judgment – are higher cognitive functions that influence the resident’s ability to coordinate complex thought and activity. A resident may find it difficult to organize his time, understand abstract interpretations in therapy, monitor his emotions, and manage his emotions. In fact, a resident with significant impairments may not clearly understand the purpose of your visits. Using simple sentences, repeating information, and making sure your requests of the resident match his capabilities can prevent the resident from being overwhelmed.

In some cases you may notice that there is an advancement of cognitive impairment even in the few weeks you meet with a resident. Although you may witness marked variability in cognitive abilities from day to day, a decline in cognition is particularly likely when the resident has experienced an acute medical problem. Some acute changes may be reversible, as when medications affect cognition. In the event of an acute change you should alert staff to what you have noticed. In terms of therapy, you may need to adjust techniques and strategies—and perhaps even your treatment goals—to accommodate cognitive changes.

Cognitive status, capacity, and informed consent

Cognitive status also is relevant to a resident's ability to provide informed consent for treatment. Informed consent implies that an individual has a meaningful understanding of what he is agreeing to. Obviously, cognitive impairment may limit a resident's ability to understand the purpose of therapy and give fully informed consent to participate. Generally, you will need to seek a balance between promoting the resident's autonomy and decision-making to the greatest extent possible, and ensuring the resident's safety. To achieve this balance, you may wish to adopt a "sliding scale" approach to decision-making capacity, whereby you weigh the resident's ability to decide to participate against the potential risks associated with treatment (Fellows, 1998). That is, when a treatment carries little risk, you may be more inclined to accept the resident's decision to pursue or not pursue treatment, even if you have little confidence in his ability to make that judgment.

Most of the literature on informed consent for persons with dementia deals with treatments that are more invasive, and therefore arguably more risky, than a psychotherapeutic intervention such as REM. Nevertheless, this literature provides some guidance regarding an ethically based decision-making process for establishing informed consent (see Fellows, 1998). First, it is strongly recommended that judgments of decision-making capacity be grounded in an explicit evaluative process, rather than being based on informal clinical impressions. You might, for example, require that the resident be able to paraphrase a description of the proposed treatment, or that he report consistent preferences on two or more occasions. Whether your residence establishes particular standards or you adopt your own, the important thing is to have a procedure in place. Documentation of this process and its results is particularly important.

Second, applying such an evaluative process, it is likely that persons with early dementia, whose cognitive deficits are *mild* or circumscribed, will demonstrate adequate comprehension of the psychotherapy process and so be deemed capable of making treatment decisions. Residents with *moderate to severe* dementia are likely to be deemed incapable of making treatment decisions independently. In these cases, treatment decisions will reflect either a "prior competent choice" standard, which stresses the values the patient held earlier in life, or a "best interests" standard, which focuses on the patient's subjective experience at the time of treatment. The "prior competent choice"

approach requires that a surrogate decision-maker (guardian, power of attorney, next of kin) be consulted. Some facilities will require this consultation as a matter of course. Find out the policy at your organization. Of course, involving a surrogate may challenge the confidentiality that is one hallmark of psychotherapy. In the case of demented elders, however, you can tell responsible others that a resident is in treatment and yet still keep most of the content of your sessions private.

- What is your client's diagnosis?

You will need to know the specific form of depression and dementia the resident has. The diagnosis of depression in persons with dementia is often difficult, as many features of depression mimic those of dementia and so may be attributed mistakenly to cognitive dysfunction rather than affective disorder (e.g., apathy, lack of initiative, poor memory). Other issues that must be considered in the diagnosis of depression include the resident's history of depressive episodes, the severity of the depression (i.e., differentiating an adjustment disorder from a major depressive episode), and the existence of other symptoms that might suggest alternative diagnoses. REM therapy is useful in each of these cases, however you may choose to emphasize different interventions depending on the specific diagnosis.

For example, knowing that the resident is suffering from an Adjustment Disorder with Depressed Mood, your treatment may focus on the transition to nursing home life or whatever else may have triggered the depression. In contrast, a resident who has had multiple episodes of depression over the course of his life might benefit from an exploration of coping responses that have proven useful in the past. Finally, a resident who has depression with psychotic features or other psychiatric symptoms more primary than depression may require other forms of intervention before you can focus on the depression.

Other diagnostic challenges exist in identifying the resident's specific type of cognitive disorder. Dementia of the Alzheimer's Type follows a different course than vascular dementia or Pick's Disease, for example. It is important for you to know the specific form of dementia the resident is experiencing, as your interventions will vary according to the expected course and prognosis.

Because of these diagnostic complexities, you are encouraged to review all previous diagnostic evaluations and consider consultation with the resident's medical care providers. If this information is lacking you may wish to request a neurological evaluation or neuropsychological testing. If you have the necessary expertise, you may choose to perform your own evaluation at the start of treatment.

- Does the resident have any sensory deficits that might influence your interactions with him?

If the resident's sensory deficits have not been addressed, you might request a consultation for an audiology or ophthalmology evaluation. You may need to speak

louder than usual to a resident with hearing loss. Sit close to these residents and speak in a slow, clear voice with a low pitch. Some residents read lips to help them understand what is being said, so sit where they can see your face. Speak into a preferred ear if the resident has one. If the resident has hearing aids, at the beginning of each session make sure that he is wearing them and they are adjusted properly. Be patient if you need to repeat information and be ready to ask the resident to verify what he has heard you say. Also keep in mind that if you need to speak loudly, you should be aware of other people around you and the volume at which you speak about personal information.

In the case of visual deficits, make sure the resident has his glasses and uses them. Visual deficits may require modification of interventions that require reading (e.g., large print), such as bibliotherapy or the use of photos, scrapbooks, or journals. Also consider how visual impairment might influence the resident's ability to respond to your nonverbal communication (facial expressions, gestures).

Deficits in taste and smell may make interventions that focus on increasing pleasurable experiences in these areas less appealing to a resident.

- Does the resident have a medical illness that could influence his participation in treatment?

Therapy may be disrupted (temporarily or permanently) by the exacerbation of a chronic illness or the development of an acute illness. In the case of minor illness, it may be possible to continue your therapeutic work, although the focus of the treatment may shift due to the new medical problem. For example, you and the resident may decide to talk about how to help him cope with the medical problem. You also might decide to postpone therapy until the resident has stabilized. An acute upper respiratory infection may make it difficult for a resident to participate in therapy for the time being, but he may be eager to restart once the infection has cleared.

In the case of more serious illness, you and the resident will need to discuss what to do. A resident who experiences a reemergence of now terminal bowel cancer may be willing to remain in therapy to address issues of death and dying. On the other hand, a resident with seriously compromised pulmonary functioning may find it too difficult to continue in a talking therapy. It may be necessary to terminate the therapy altogether if you believe the therapy cannot be helpful or may even be a hindrance to the resident.

Be watchful for changes in cognition that might appear. Residents who go into the hospital, even for minor and brief stays, may be more disoriented and cognitively impaired when they return. Most residents will experience a gradual improvement in cognition over the first few days or weeks. For other residents the hospitalization may mark a permanent deterioration in their cognitive status that influences your treatment goals and strategies.

- Is the resident taking medications that could influence therapy?

The main concern here is with side effects. It is important to investigate whether

abnormalities or changes in mood, cognition, or behavior may be due to pharmacological effects. For instance, the possible side effects of antihistamines can include impaired concentration and lethargy. Antihistamines have anticholinergic effects that might be even more extreme in an individual whose cholinergic system is disrupted, as is the case in Alzheimer's disease. Pay attention when a resident's medications have been modified— new ones added, old ones discontinued, dosages increased or decreased—as changes in the resident are more likely to occur then.

Another consideration is how the timing of medications might influence your work. For example, if a resident takes medication for chronic pain, it may be helpful to schedule therapy appointments when the medication is in full effect to prevent distraction during the session. Similarly, you may not want to schedule sessions for the time when a sedating medication begins to take effect.

A final issue involves cognitive enhancing medications. Currently, a number of medications are available to enhance cognitive functioning. The long-term clinical benefits of these medications remain uncertain, but some individuals experience improvements in cognition and functioning, at least in the short term. Be prepared to discuss a resident's expectations about the effectiveness of these medications. By taking these medications, some residents may experience periods of cognitive clarity during which their circumstances become more apparent to them. Being forced to acknowledge one's dementia again and again can be discouraging. Keep in mind that, despite their promise, these medications are not always effective, sometimes are poorly tolerated, or may have effects that are disappointing relative to the resident's expectations. You may find yourself talking about these issues in therapy, as well.

- Does the resident have physical needs or impairments that you should take into account?

Here are a few examples of ways in which the resident's physical needs may influence your work. An older adult with difficulty walking may have trouble meeting you at an office. It may be necessary for you to arrange transportation for the resident or to get him yourself. In the latter case, you may need assistance helping a resident into a wheelchair. Even though you meet for a relatively short time, a resident with chronic pain may find it difficult to sit comfortably during your sessions. You may want to talk about whether some breaks during the session for repositioning are helpful. A resident who needs to use the restroom is likely to have difficulty concentrating during the session, so be sensitive to that need as well. Pay attention to the temperature of the therapy room; a resident may want it to be warmer or cooler than you think, and it is worth asking about his preferences. Providing a comfortable chair for the resident, having a beverage available, keeping a box of tissues in the room—these preparations can enhance the resident's experience in therapy.

- What does the resident think about therapy?

Older adults are part of a cohort for whom mental illness was viewed as a personal defect or at least something shameful that should not be discussed openly. Consequently, some older adults believe that emotional difficulties are the realm of “crazy people” and that reasonable people should keep their problems to themselves or should be able to get better by sheer force of will. Sharing emotional problems with a stranger is not seen as appropriate. Indeed, acknowledging emotional problems to oneself is not encouraged. Instead there is an expectation to “pick yourself up by your bootstraps.” The need for psychotherapy may be interpreted as evidence of personal failure. In this situation it may be helpful to remind the resident that agreeing to treatment is, on the contrary, evidence of strength.

When a resident has had little prior experience in psychotherapy, the process may be somewhat mysterious. A resident may wonder, “How can simply talking about things possibly help me?” He may be more accustomed to, and more comfortable with, a medical model of treatment that focuses on taking medications to address problems. And he may be skeptical that talking with you will help him. Negative expectations also may be part of the resident’s depressive, pessimistic thinking. It is useful to investigate these concerns early in treatment. In addition, you can emphasize to the resident that you have professional training that can benefit him (see Chapter 6: *The First Session*, for further guidance on explaining your education and credentials).

For a resident who has had psychotherapy before, it is important to explore what that experience was like for him. You may be able to use positive past experiences to enhance the resident’s motivation in the current treatment. Negative experiences should be discussed openly so that you are aware of the resident’s concerns and can work to make similar disappointments less likely in the current therapy.

As treatment progresses, it is important for the resident to be aware of his important contribution to his therapeutic gains. Although it may be difficult for the resident to coherently articulate how he is getting better, attributions for therapeutic success that recognize his role in the process will be translated into a positive feelings about himself and a sense of optimism. For some residents you will play an important role in identifying improvements and pointing out progress when they are unable to reflect on them spontaneously.

- What does the resident think about you?

Older adults may have a tendency to overidealize you, just as they do other health professionals (“You’re the doctor so I’ll do what you say.”) Be aware of the potential consequences of that attitude. First, it places pressure on you to make sure the resident improves. It also can locate the cause of improvement with you rather than with the resident. As mentioned earlier, it is helpful for residents to make attributions for their improvement that reflect their own contributions.

You also may want to consider potential transferences that the resident may

develop toward you. A resident may think of you more like a son or daughter, or perhaps even like a grandchild, rather than a professional. That kind of attitude may dilute the therapeutic relationship. On the other hand, your position as a respected health professional may enhance the resident's feelings of self-worth as they "borrow" your prestige (Tobin, 1999). "There must be something worthwhile about me if this important person is taking the time to visit me," may be the thought. In the context of dementia, transferences may emerge more readily and freely, as residents become more affectively disinhibited and as self-monitoring and self-editing wane.

- How might the resident's cultural background influence therapy?

In working with clients of any age, therapists need to have an understanding of the values, beliefs, interactional styles, and expectations of diverse cultures. Knowledge and skills for multicultural assessment and intervention include the ability to understand the socioeconomic and political factors that affect the psychosocial well-being of culturally diverse groups, and to help clients understand, maintain, and/or resolve their sense of cultural identity. Cultural variations play a role both in the particular issues that may present in therapy and in the therapeutic process.

Regarding the process, a client's culture may influence such things as his interpretation of his psychiatric symptoms, his expectations for therapy, his views of the therapist and the therapeutic relationship, and his understanding of his own role in the therapy. Given twentieth century immigration patterns, you are likely to encounter many older clients who were born in European countries. Persons who immigrated to the U.S. will be acculturated to varying degrees, and you need to consider their unique experiences in your treatment. To what extent do they identify with the culture of their original home or ethnic group? To what extent do they identify with the majority culture? How might the unique culture of their ethnic group influence the expression of their psychiatric problems and the best methods to address them? These are just a few of the questions you might consider in this complex but important topic. For more on this topic, see Crose (2000), Gelfand (1994), or Valle (1998).

- How might the resident's spiritual beliefs influence therapy?

Because a person's spiritual beliefs may provide an important source of strength and comfort, you should assess the degree to which the resident relies upon his spiritual beliefs to cope with life's difficulties. Knowing the resident's spiritual beliefs, you can integrate them as appropriate in your treatment. For example, a resident who holds strong beliefs in an afterlife may respond well to your attempts to foster his acceptance of death. Someone whose spiritual beliefs include an emphasis on doing "good works" may feel motivated to help others, fostering a sense of agency and a feeling of being needed.

Participation in spiritual activities also may be a focus of treatment. Helping the resident attend religious services may be valuable for residents who have been interested

in attending but unable to work out the logistics on their own. Providing a way to help the resident be able to listen to services on the radio or on television also may be appealing. Visits from clergy may be desired. These interventions can be therapeutic because they acknowledge personal preferences and values at the same time as they enable residents to employ their spirituality as a positive force in their lives. Readers are referred to Koenig (1994) and Lewis (2001) for more information on how to bring a resident's spiritual beliefs to bear in treatment.

- How might the resident's personality influence therapy?

As with clients of any age, older adults may have personality characteristics that impede or facilitate therapy. Hostile, antisocial, or paranoid characteristics, for instance, can make it difficult to establish a meaningful therapeutic bond. Other personality features bring different challenges. A resident who is timid, passive, and dependent may have difficulty being assertive with staff or may find it difficult to end therapy with you.

When considering personality it is important to distinguish between characterological features that are part of the resident's nature and those that are due to neurological disease. Overall, research suggests that personality is relatively stable throughout life. An older adult's personality is likely to be consistent with the personality he had when he was younger. On the other hand, personality changes can be a symptom of Alzheimer's disease or may be an indication of some other form of disease. Gathering a thorough history, with input from family members or friends who have known the resident for some years, can help put current behavior into perspective. Family members may tell you that over the last few years the resident "just hasn't been himself," or, "he was never as short-tempered as he is now." Other times you may hear, "Oh, ever since I've known him he has been a complainer, kind of pessimistic." That kind of information may help you understand the resident's current behavior.

It is not the purpose of REM therapy to perform wholesale personality restructuring. When you work with a resident who has substantial personality difficulties, perhaps even a personality disorder, you may need to make significant modifications in treatment goals so that they are realistic and attainable given the limitations imposed by the resident's personality characteristics. For example, it is unlikely that REM therapy will be able to help a person with lifelong dependent personality features achieve a significant level of autonomy. Your interventions with such a client should reflect a realistic goal, such as helping the client to become independent in a limited domain.

- What "rewards" does the resident receive for being depressed?

It may sound odd to think about depression bringing "rewards," but being psychologically disabled can be reinforcing. For instance, a resident who is depressed may receive special treatment from family members or from staff. He may get to stay in bed longer, may receive more attention, or may simply get treated with more care and

concern. These secondary gains can encourage a resident to remain disabled. When rewards and reinforcements for being ill are positive and powerful it may be difficult to make therapeutic progress.

For more detailed information about working with older adults, we refer you to the excellent, comprehensive resources suggested in the Appendix.

🕒 Aspects of the therapist

- What are your stereotypes of older adults and their ability to benefit from psychotherapy?

Some therapists hold stereotyped or prejudiced notions about what older adults are like. For example, a therapist may believe that older adults are not interested in sexual activity or are not sexually active. That therapist may not think to inquire about intimacy issues, even though it may be an important part of why a resident is distressed. Likewise, therapists may doubt that psychotherapy can be useful to someone with significant cognitive deficits, particularly memory problems. When so much of therapy seems to depend on an intact mind, how can it work with people who have a brain disease? Thankfully, that kind of therapeutic nihilism is increasingly contradicted by both ethical considerations (Kitwood, 1998) and research (Kasl-Godley & Gatz, 2000).

At a basic level, a therapist must believe that depressed, demented individuals can benefit from treatment. Stating this may seem unnecessary to someone who is taking the time to read this manual. But many people—therapists included—think that old age brings natural reasons for being depressed, or that dementia brings impairments in memory and thinking that make any type of talking therapy pointless. Anyone who has worked with nursing home residents knows that is not true. A successful therapist will have positive expectations for therapeutic change. And that therapist will convey those positive expectations and hopefulness to the resident.

- How might your own feelings about aging and the long-term care setting affect your work?

The idea of growing old—with its physical, mental, and social changes—may be frightening, even to the most level-headed and therapist. Working with a resident who has cognitive impairments also might be of concern, particularly to a young therapist who relies on his mind to do his work. Therapists who feel uncomfortable about issues of loss of control, who are anxious about physical illness or death, and who are anxious about “losing one’s mind” in the context of dementia may find it difficult to work with older adults in nursing homes. Therapeutic success depends on the therapist being aware of these issues and adequately resolving them.

Therapists also can gain much from paying attention to the influence of their own relationships with older adults in their personal lives. Countertransference issues related

to previous relationships, including relationships with one's own parents or grandparents, can influence the therapeutic work.

Finally, therapists who are accustomed to performing individual psychotherapy in an outpatient setting such as a private practice should be prepared for the unique elements of working in an institution. Therapists may have preconceived ideas and perhaps apprehensions about what a long-term care residence will be like, including the physical environment and the staff. Be watchful about how your attitude toward the environment can be communicated to your clients, even unintentionally.

- How flexible is your therapeutic approach?

Therapeutic work with older adults requires a flexible technique. Therapists who are intent on retaining firm boundaries with the resident may face a cold and disinterested response. For instance, older adults may benefit from (indeed, may expect) a higher degree of personal disclosure than younger adults. Disclosure can be beneficial when it solidifies the therapeutic relationship and puts the resident more at ease. When a resident asks whether you are married or whether you have children, that may simply be his way of establishing a connection with you. Residents may be following their own rules for polite discourse; they were brought up to be interested in others, to ask friendly questions when a visitor comes to see them. It may not be necessary to interpret their probing as defensive or sly. They may simply be taking advantage of the opportunity for normal social interaction, something they might not have much opportunity for in their current living circumstances.

During your sessions you also may need to be more active than with younger clients: frequent prompts, encouragement, reinforcement, and direction may be helpful. Similarly, for younger clients you might not consider watering their plants when asked, but this type of small favor may bring you closer to an older resident and gain you leverage when it comes to therapeutic issues. You may find that some residents will ask you on occasion to help them with minor, day-to-day tasks. Hanging pictures, getting things from drawers, bringing a drink, dialing the phone, writing brief notes—these favors are not typically part of what a therapist does for a client, but with some older adults they may help strengthen the therapeutic alliance. (Note, however, when this becomes a pattern that may be related to dependency issues.)

A final consideration is the issue of touch in therapy. Most practitioners are guided by ethical considerations regarding physical contact with their clients. Many clinical training experiences teach psychologists to avoid all touch between a therapist and a client. It is our belief that touch can be integrated when working with older adults in a way that is ethical and therapeutic. Clients are likely to have different attitudes about touch, though, and therapists should always respect their client's wishes in this regard. Nonetheless, do not underestimate the importance of physical touch with some older clients. Grunes (1987) has suggested that changes in the body with aging can leave older adults feeling unattractive and "untouchable," thereby enhancing the importance of appropriate touch in the psychotherapeutic relationship. Holding a hand, touching gently

on the arm, giving a hug—these may be rare and welcome connections for the resident. Most long-term care residents are only touched in a functional, mechanical manner, for instance when they are helped out of bed, helped to the bathroom, or scrubbed in the bath. Gentle touch that conveys warmth and caring can be powerful in your therapeutic role.

⑥ Aspects of the family

- How can family members support the resident?

Family members can be an important resource in your work with residents. They can monitor the resident's mood and behavior between sessions, motivate the resident to follow through with interventions, assist with interventions, and provide emotional support.

- How can family members hinder the resident's progress in treatment?

Family members may sabotage treatment goals by reinforcing dependency. For example, a family member might do too much for a resident. You may be trying to help a resident reach maximum independence, but you may learn that the resident's daughter visits and does things for him that he is capable of doing for himself. Or, the daughter may attend care planning and bring up the resident's concerns rather than having him express them himself. In this situation you will need to work with the daughter to help her see the importance of the resident's continued independence.

A subtler example might involve a niece who has taken her aunt out of the nursing home each weekend. Although her aunt enjoys these trips, they are difficult for the niece to arrange. Now the aunt is depressed and unmotivated to leave the nursing home. The niece finds this to be a relief, because it frees her from the obligation of making those difficult trips. The niece may have little motivation to cooperate with your attempts to reinstate the weekly outings, and she may hinder your attempts to get her aunt back into that routine.

Family relationships that have been poor for many years may inhibit progress by dredging up old conflicts that undo gains you make in the resident's mood and attitude. Conflicts from many years ago can still have a direct impact on family communication and behavior.

And finally, when a transference emerges in which the therapist is identified with a family member, the transference can be beneficial to the therapeutic relationship when the family member is associated with positive feelings. On the other hand, difficulties can emerge when the family member with whom the therapist is identified is a negative figure in the resident's life. Some therapists may be surprised that strong transferences develop even though the therapist may be remarkably different from the relative in the most obvious ways. For instance, a male therapist may be identified with a female family

member. A young therapist may be identified with a resident's mother. Particularly when the resident's cognitive impairment is more advanced, transferences may take on many forms.

④ Aspects of the institutional setting

- How can daily life in an institution influence your work?

For all its structure and routine, a long-term care residence is a living environment where unexpected events and changes are common. Breakfast may be very late one day. A resident may not get his bath at the time he expects because a staff member called out sick. A favorite shirt may get lost in the laundry. A roommate may become ill and die unexpectedly.

These events may be genuinely distressing for residents, and they may be the first things they want to talk about with you. They can arise at any point in the course of treatment, and they deserve attention. Although the purpose of REM therapy is to address a resident's depression, it is important to be flexible and respond to an acute crisis when needed. In fact, in many cases these events may be an integral part of why the resident is depressed. These day-to-day challenges can affect a resident's mood, optimum functioning, and quality of life.

- food complaints
- bad odors in the residence
- ambient temperature problems
- boredom
- never getting a change of scenery
- limited range of available activities
- inattentive staff
- infantilizing treatment by staff or family
- roommate conflicts
- family doesn't visit or call enough

Although these concerns seem quite mundane, they deserve to be addressed in therapy and often are related to more broad, abstract issues that are connected to the resident's mood and functioning. For example, you may tackle a roommate problem in therapy and reach a solution regarding that specific circumstance, but the roommate problem also may provide an opportunity to address a more general issue in the resident's life, such as difficulties in reaching out to others in a constructive way.

- How can you find a private place to conduct therapy?

Therapy is a confidential endeavor, yet often the residence provides few spaces for meetings between you and the resident. Finding private space for your sessions conveys that these are important meetings, that the resident is important and deserves privacy. It also reinforces the professional nature of your relationship with the resident, distinguishing it from a friendly visit.

You may need to be creative in seeking out quiet, private places to meet: staff

offices, reading rooms, small visiting rooms, empty resident rooms, outdoor spaces, and rooms in the residence that are traditionally used for other purposes might be commandeered for your sessions. If you truly cannot find a place to meet in private, at least try to be as far away from others as possible. Ask a roommate if he is willing to leave the room for a few minutes, or at least draw a curtain between beds.

Also be aware of confidentiality and privacy when approaching a resident for your appointment. When a resident is sitting with friends, don't walk up and say, "Hi, Mrs. Clarke. I'm going to take you upstairs for your therapy appointment." This is a simple consideration, but some residents may prefer for other residents not to know the nature of their relationship with you. On the other hand, word gets around in a residence, and in reality it will be difficult to maintain perfect confidentiality.

- How do you make sure you don't interfere with other staff and routines?

Talk with staff before scheduling your sessions to avoid potential conflicts with meals, baths, medical appointments, rehabilitative therapy sessions, group activities, or other routines. When staff know about a resident's appointments they can make sure that the resident is ready (i.e., is dressed and has used the bathroom recently). It is important to let staff know that you are aware of their responsibilities and schedules and do not want therapy to interfere. On the other hand, you also want staff to know that therapy is important and needs to be thought of as part of the resident's plan of care.

- How do you communicate with staff about the resident without breaching confidentiality?

There are two issues here: 1) letting the staff know the resident is in therapy, and 2) letting the staff know what is happening in therapy. Although a resident's participation in therapy is confidential, it may be unavoidable that some staff members know you are meeting with the resident. Members of the treatment team, for instance, should have that information, and those whom you rely upon to locate or prepare the resident will be aware of your meetings. More peripheral staff, however, do not need to know that the resident is in therapy.

In terms of providing information about a resident's status or progress in treatment, before you share information with the staff, discuss with the resident what you want to share and why you think it is necessary. Respect the resident's wishes to the extent allowed by ethical considerations. Share with staff just the details they need to know in order to help the resident with therapeutic interventions or monitor the resident's behavior. Most of the content of your sessions can remain confidential.

Also be aware that the resident's chart is more public than a traditional psychotherapy record. Be thoughtful about what you record in the chart. In general, your note should include:

- information about the resident's current functioning (including specific

- symptoms and the continued medical necessity of therapy),
- general content of the session (here you should be particularly careful about disclosure of unnecessary detail),
 - progress toward goals and plans for future sessions.
- What do you do when staff disagree with treatment goals or fail to assist with therapeutic interventions?

Despite your good intentions and despite the efforts of the resident, you may find that the staff, on occasion, may thwart the goals you are working toward. For instance, imagine that you have a plan to increase the resident's sense of control and independence by requesting a Physical Therapy evaluation and getting the resident on a daily walking program. The resident is enthusiastic about regaining mobility and is motivated to work toward this goal. With the assistance of a nursing aide, you set up a walk schedule according to which the resident will walk, with stand-by assistance, for 15 minutes every afternoon. Unfortunately, afternoon responsibilities change and make it difficult for the aide to spend time reliably with the resident. Therefore, the walking program falters and the resident does not have the chance to make the physical gains he could. In another circumstance you may set up the walking schedule, but the aide may claim he does not have the time to spend with the resident.

Staff members may be unwilling to participate in treatment initiatives, may disagree with their appropriateness, or may not understand their necessity. "He's demented. What good is that going to do?" is one potential staff response. "Of course he's depressed. That's just how he is," is another. Education and information about the negative effects of depression (i.e., poor motivation, apathy, social withdrawal) may help with resistant staff attitudes. Staff also may believe that they know that the treatment will not work, perhaps because of disappointment with past attempts; they may be reluctant to try, yet again, to help the resident improve.

Most staff are busy trying to do their job in the most efficient, caring way possible. So when you approach them with an intervention that requires their time, their first reaction may be unenthusiastic. Staff may feel overburdened and unable to fit in yet another treatment initiative. It is up to you to help them understand how your interventions may benefit the resident (and perhaps the staff too, by making a resident less dependent or more cooperative). Getting them involved in the process from the start is one way to get their support. Meeting with the resident and nurse's aide, for instance, can create an atmosphere of teamwork and cooperation.

Staff may believe that "this isn't part of my job, that's what you psychologists are for." This may be indicative of a larger problem—an administration that doesn't value or promote a psychosocial care orientation among its direct care staff. In such cases, your efforts will need to begin with educating and enlisting the support of administrative and supervisory staff to ensure that treatment initiatives are implemented. Without

acknowledgment from senior staff of the importance of the therapy and its goals, other staff may not feel invested in the process or willing to follow through with their responsibilities. You may think to yourself, “It’s their job to do it, so why do I have to cajole and plead with them?” The reality of the situation is that some staff members will need motivation from a superior to follow through on your interventions.

It is important to recognize that as a resident becomes less depressed he may make more demands on the staff. When apathy and withdrawal start to subside, a resident may be more vocal with the staff and assertive about his needs. Staff may not always welcome that activation. They may have a subtle incentive to keep a resident dependent and even depressed because his improvement may place greater demands on them. It is a good idea to prepare the staff for this possibility.

Finally, there are times and places when it is not realistic to get assistance from staff. For example, a resident who wants to have a whirlpool bath every day may have to accept that this is untenable. Knowing when to focus on other interventions is a key element of good clinical judgment.

- Why do some of the aids you create for residents disappear?

Logs, journals, photo albums, and signs that you create with the resident may be misplaced or taken from the resident’s room. Keep these items in a safe place that is still accessible to the resident. Also let senior staff know they are there so that others can be watchful for them.

- How will you get reimbursed for your work?

This question brings up an issue too large to address here in detail, but you should be aware that reimbursement for your sessions may vary depending on the provider you are billing and their policy regarding psychotherapy, particularly psychotherapy with individuals with dementia. Recent initiatives, for instance, have been successful in making sure that a dementia diagnosis is not automatic grounds for rejecting a Medicare claim, but the degree to which psychotherapeutic services for individuals with dementia are reimbursed remains uncertain. Although REM treatment is designed to last approximately 16 sessions, you may find that reimbursement organizations require shorter treatment. We offer this potential barrier with little advice but rather as a warning that the health care system is still in a great state of flux, and reimbursement for psychotherapy has not settled into a predictable pattern.

A summary of clinical questions for you to consider

Aspects of the client

- What is the cognitive status of your client?
- What is your client's diagnosis?
- Does the resident have any sensory deficits that might influence your interactions with him?
- Does the resident have a medical illness that could influence his participation in treatment?
- Is the resident taking any medications that could influence therapy?
- Does the resident have physical needs or impairments that you should take into account?
- What does the resident think about therapy?
- What does the resident think about you?
- How might the resident's cultural background influence therapy?
- How might the resident's spiritual beliefs influence therapy?
- How might the resident's personality influence therapy?
- What "rewards" does the resident receive for being depressed?

Aspects of the therapist

- What are your stereotypes of older adults and their ability to benefit from psychotherapy?
- How might your own feelings about aging affect your work?
- How familiar are you with therapy modifications that may be needed with this type of client?

Aspects of the family

- How can family members support the resident?
- How can family members hinder the resident's progress in treatment?

Aspects of the institutional setting

- How can daily life in an institution influence your work?
- How can you find a private place to conduct therapy?
- How do you make sure you don't interfere with other staff and routines?
- How do you talk to staff about the resident without breaching confidentiality?
- What do you do when staff disagree with treatment goals or fail to assist with therapeutic interventions?
- Why do some of the aids you create for residents disappear?
- How will you get reimbursed for your work?

Chapter 4 ~ The Importance of a Systems Perspective

One traditional approach to psychotherapy focuses on the therapist and the client and what the two of them do together. A focus on the dyad, however, may overlook other influences that are important to the mental health of a long-term care resident. Relationships with family members and staff, for instance, are important aspects of a resident's daily life. In addition, there are other aspects of living in a long-term care residence that play a role in mental health. Activities in the residence, interactions with physicians, and environmental features such as lighting and the use of space, as only a few examples, can influence the resident. REM therapy utilizes a "systems" approach that acknowledges the entire context in which a resident lives and incorporates the many relationships and experiences in a resident's life.

Of course a systems approach requires that therapists be aware of the multiple systems within which a resident functions. How do you learn about the system? You could undertake a formal evaluation, with questionnaires and surveys. More realistically, your assessment will be informal. You'll learn about the system by spending time with the staff, talking to family members, and observing life in the residence. This is a process that occurs gradually. The more time you spend there the more you will learn. Still, there are elements of the system you can start investigating early in your relationship with a resident. For example, you can begin to notice aspects of the physical environment and learn about day-to-day routines in even your first meeting.

In this section of the manual we discuss some aspects of staff and family systems that warrant assessment (or at least consideration) as you think about your interventions.

The staff system

There are at least six elements of the staff environment that have an impact on residents: power, structure, communication patterns, staff backgrounds, staffing patterns, and organizational philosophy. Here we talk about each element in brief, followed by examples of how these elements may be important to your treatment. A number of excellent resources can give you a more complete discussion of environmental contexts. We refer interested readers to works by Rader (1995), Caron (1997), and Molinari (2000).

- **Power**

One aspect of the staff system that is valuable for a therapist to understand is the nature and distribution of power. Who has it? How is it organized (horizontally,

vertically)? How is it wielded (wisely, impulsively)? Issues of staff power are played out in a residence in many ways, both subtle and obvious.

You can begin to learn about how power is distributed in an organization by examining the supervisory structure. What is the chain of command? What is the hierarchy of nursing assistants, charge nurses, unit managers, etc.? How rigid is that hierarchy? Similarly, how cohesive is the staff on the unit? For instance, do the CNAs have casual conversations only with the other CNAs, or is there camaraderie among all levels of staff? Is there evidence of conflict among the staff, and how is that manifested? For example, do staff members ignore one another or make negative remarks? Also, how do staff feel about management and the organization where they work?

“I can’t do everything!”

You and your client, Mr. J, have been talking about how important it is for him to be able to dress himself each morning. This takes a while, but it is important to Mr. J’s self-esteem and sense of personal accomplishment. Tracie, the CNA who works with Mr. J, usually dresses Mr. J as quickly as possible so she can get to her other duties. You’ve talked with Tracie and the nurse manager together about giving Mr. J more time in the morning, but Mr. J tells you Tracie continues to rush him through dressing. You later learn that Tracie and the nurse manager have been having perpetual disputes over Tracie’s schedule. When you talk with Tracie you learn that she is getting pressure from the nurse manager to get her work done quickly, and she doesn’t feel that she has the flexibility to let Mr. J take more time in dressing. You may need to have an additional meeting with Tracie and the nurse manager to emphasize the importance of dressing to Mr. J’s mental health and to discuss ways to accommodate him. In this situation, appreciating how power is wielded in these professional relationships can help you implement one aspect of your treatment plan.

You may want to keep your eyes and ears open for the ways in which informal power is used on the unit. Some staff members may be influential because of their personality or status, even though they may not have a position of formal power. Most staff are well aware of how power is distributed on a unit and throughout a residence, although they may not talk about it overtly.

Another way to learn about power in the system is to learn about the institution’s policies regarding remediation and punishment when an employee exhibits poor

performance, as these policies represent an invisible player in the residence's power hierarchy. Is there a formal system of punishments in place, as well as a complementary system of reinforcements for positive behavior? What is the strength of union representation in the organization, and on the unit in particular?

It also would be helpful for you to know how staff feel about consultants or staff members, such as yourself, who are not part of the regular unit staff. Are they viewed as competitors or collaborators? Do the staff worry that consultants or other staff off the unit will create more work for them? Or do they view them as people who can help them do their job more effectively? You also should be aware of the recent institutional history (conflicts, successes) that might influence staff attitudes or perceptions of you.

Power also is an issue in relationships between staff and family members. Some staff may view family members as demanding and adversarial, people who don't appreciate the difficult work they do. Family members, on the other hand, may feel staff don't acknowledge the expertise and knowledge they can share. And they may see staff as workers who make little effort to provide genuine care to residents. Staff-family conflicts often revolve around uncertainty about the division of labor, about who is responsible for providing psychosocial support to the resident.

“We’ve already tried that!”

You are consulting with a nursing home and have created a behavioral plan to get a depressed resident, Mr. K, out of his room more often. Mr. K has told you he would like to watch the Olympics on television in the common room. Together, you and Mr. K have devised techniques the staff could use to encourage him to leave his room and watch TV. When you approach the staff with these suggestions, they say, “We tried something like that with another psychologist who was here last year, and it didn't work. It's not going to do any good now either.” Your intervention will fail if you don't have the support of the staff. Consequently, you will need to spend some time talking with them about what happened before, what frustrations they experienced, how they might recommend modifying the intervention to make it more successful, and how you can help them. Talking with staff about their expectations, devising ways to show them how they are contributing to the resident's improvement, and getting them invested in the intervention will increase your chances of success.

- Communication

Everybody needs information to do their job, but some organizations are better at distributing information than others. It is worthwhile for you to be aware of who delivers information in your residence, how often is it shared, and whether it is shared freely or handed out in spurts with staff members left on their own to piece together a full picture of situations.

Communication is important to your activities as a therapist for a number of reasons. For instance, you may need to know how information is communicated about a resident's functioning; how do the staff on the night shift communicate events to the day shift? And how is that information available to you? Similarly, when you are planning interventions, how can you make sure your intentions are adequately communicated to the staff involved? In your work, consider patterns of communication among the following groups.

Communication between shifts. Is there a formal mechanism for sharing information between shifts? A written report? A verbal exchange at the change of shift? How can you make sure information about your treatment plan gets passed along? This is important if you devise interventions that require the help of staff from all shifts. For instance, if part of your treatment plan is to have the resident attend evening activities off the unit, you will need the cooperation of evening staff to make sure transportation is arranged.

Communication between staff levels. How does the nurse manager communicate with the CNAs? How does the Director of Nursing communicate with the nurse managers? If the nurse manager is aware of an upcoming schedule change, how and when is that information shared? How are treatment recommendations and goals communicated to staff who do not attend care planning meetings?

Communication between disciplines. In a true interdisciplinary team there is smooth communication between social work, nursing, therapies, medicine, dietetics, activities, psychology, etc. If you have treatment goals that require collaboration among disciplines, effective communication will be important. For instance, you may be working with a resident who enjoys cooking, and you may talk to the Activities Coordinator about getting the resident involved in cooking activities. Because the resident is lactose intolerant, you may need to have the Dietary staff talk with the Activities Coordinator to make suggestions about appropriate recipes.

Sharing information with psychiatry is an especially important part of your communications. If the resident you are seeing also is seeing a psychiatrist, make a special point of communicating, in writing or verbally, about your treatment plan and progress toward treatment goals. Similarly, it may be

helpful to speak with the psychiatrist or psychiatric nurse about how psychotropic medications and psychotherapy may complement one another.

There is an extensive literature available on interdisciplinary collaboration in long-term care. Resources worth visiting include Karel, Ogland-Hand, Gatz, & Unuetzer (2002), Ogland-Hand & Zeiss (2000) and Zeiss & Steffen (1996).

Communication between staff and resident/family. How often is the resident's treatment discussed formally with him/her, and what goes on during the process? Does the resident routinely participate, and does that participation genuinely involve the resident or are residents invited merely as a formality? Does the family routinely participate in care planning meetings, and is their participation genuinely welcome? If you've achieved success encouraging the staff to provide positive reinforcements for adaptive behavior, you don't want their good work undermined by family members who aren't aware of the successes that the staff experience.

- Staff backgrounds

Staff members have various reasons for having the job they do. Those differences and reasons may affect their motivation and, in turn, their availability to help you help the resident. For instance, a CNA who cares deeply about the residents and feels proud of her caregiving role might be an excellent person to include in an intervention. On the other hand, a staff member who is just there for the paycheck may be less helpful.

Learning something about staff training background also can provide information about the competencies you can expect from them and the areas in which you may need to offer additional education and support. For instance, some staff may have substantial training in detecting emotional symptoms in older adults, while others may have little or no experience with mental health issues. When staff feel well prepared for and skilled in their job responsibilities, they are likely to be more motivated to extend themselves to help a resident.

It is also worth learning about a staff member's routine and how that might influence interventions you plan with him or her (e.g., when do they give baths, when are their breaks, how many other residents are they responsible for, etc.). Likewise, if you intend to rely on a particular staff person, consider what that will do to his or her level of burden or stress and how you might help manage it.

This brings up the more general issue of stress that staff experience. Direct care is demanding, both physically and emotionally. Likewise, unit coordinators who are responsible for balancing administrative duties and management responsibilities can be under a great deal of stress. Are there support services available to staff? What kind of training opportunities do they have? How do support and training opportunities relate to career advancement potential? Do they feel they are part of a team that values their contributions? What kinds of positive reinforcement do they receive? Can you offer

support yourself or suggest to the administration ways that you might be helpful? Some staff may view your involvement and recommendations as an added burden to their already hectic schedule. Consider how your interventions can be framed so they benefit staff too (e.g., a resident who is less depressed may function more independently and require less staff assistance).

“Why won’t the staff help me?”

You have developed a strategy to enhance Mr. N’s self-esteem, but you find yourself frustrated by a CNA who doesn’t appear willing to cooperate with the intervention. Initially you talked with the CNA about promoting the continuity of Mr. N’s past roles by having the CNA review a scrapbook with him every morning. The CNA politely acknowledged the value of the intervention when you first talked with her, and she seemed willing to follow through. Later you discover that she has been too busy to do it. As you think about how to address the situation, you consider that the timing of the intervention might have been inconvenient. The CNA’s morning is taken up with physical care tasks, and she can’t find the time to sit with the resident. So you approach the CNA again and suggest that it might work out better if she chose a time for the intervention. She agrees and chooses a different time, but even that doesn’t work. She continues to claim she is too busy to sit with the resident.

Another explanation for the failed intervention occurs to you. Many staff members have training that emphasizes “bed and body” work and not psychosocial care. The CNA may not think that sitting with the resident is a legitimate use of her time. In addition, she may feel uncertain about her ability to carry out the intervention. You talk with the nurse manager, who communicates to the CNA that reviewing the scrapbook is a legitimate job responsibility, and together they find a way to fit it into her schedule. In addition, you spend time with the CNA teaching her how to make conversation, draw the resident out, and attend to emotional reactions during the intervention. The CNA feels more able to fit the intervention into her schedule with the support of the nurse manager, and she feels more confident in her ability to make a difference in Mr. N’s life because of the preparation you provided.

- Staffing patterns

Learning a few details about basic staffing information can provide a great deal of insight into the work environment. For instance, what is the staff turnover rate? A high rate might indicate something negative about the work atmosphere. What kind of input do staff have in the scheduling process? If staff are reassigned frequently and abruptly from unit to unit there is little opportunity for them to develop any sense of cohesion with their peers, not to mention consistent relationship with the residents. Is there primary assignment to residents and to units? For permanently assigned staff, how do they manage burnout when working with difficult residents? Can they request reassignment without penalty? How do the administration and unit staff respond when they are short staffed? Staff members who are present may be expected to take up the slack, increasing their stress level and probably increasing their dissatisfaction as well. In addition, when staff assignments change frequently it is important to keep in mind that any intervention you attempt may be diluted in its effectiveness and will require more educational oversight on your part as the consultant.

- Philosophy

You can learn much about the residence's approach to residents by reading the formal philosophy or values statement. How does that document portray the balance between medical care and psychosocial care? Is there explicit mention of respect for individuality and the needs of residents? Beyond the document itself, how do the institution, its policies, and staff encourage individualization? For instance, some facilities may conduct a formal assessment of personal preferences regarding care routines, activities, foods, visitors, etc. If so, you may want to know how those personal preferences are integrated into care. Some indicators of a personalized environment include the following:

- residents are allowed to wake up at any time they choose rather than following a unit schedule;
- residents can bathe when they wish and as often (or not often) as they wish;
- residents are given a range of choices for meals;
- residents are allowed to personalize their rooms with their own furniture and decorations;
- residents are addressed in a respectful manner, and staff use the form of address residents prefer;
- activities are varied and driven by resident wishes;
- private places are available for sexual activity for those residents who are interested.

As you learn about the overarching philosophy of the organization you can get a better sense of what interventions are possible within the residence and what type of

support you might expect for your plans. For instance, adapting a bathing schedule for the benefit of the resident is easier to accomplish in some organizations than in others, depending on their commitment to individualized care.

Practice that matches philosophy

You are treating a resident who has had several falls recently and is now recovering from a hip fracture. Mrs. B is depressed about her current limited functional capacity and is responding to her distress by “giving in” to her disability. She doesn’t believe that she is capable of resuming her ability to walk and is asking the staff to do more and more for her. Fortunately, the residence has stated in their philosophy a strong commitment to encouraging the highest level of independence in their residents. This commitment is explicitly stated in the philosophy and is evident in the types of programming and staff in the residence. The resident you are treating is entered into a restorative care program where physical and occupational therapists help her reach and maintain her highest level of functioning. PT and OT also train nursing staff to provide extra verbal encouragement and reinforcement for progress made.

Being familiar with the philosophy of the residence can help you understand the environment in which the resident lives, and can assist you in developing realistic expectations in your treatment interventions and goals.

The family system

Although in therapy you focus on one particular resident, behind the scenes is a large cast who have played a significant role in the resident’s life—family members. Family issues remain important even after people have moved into a long-term care residence. Indeed, your work is likely to include discussions about important past and current family events and relationships. Family members also can be important resources in your treatment, assuming you have a comprehensive perspective on how family relationships are important to the resident. Here we discuss two issues related to family involvement: resident contact with family members and enlisting family support for your interventions.

- Resident contact with family members

Family members stay in touch with residents via phone calls, letters, cards, and e-mail. But the most obvious way that family members maintain contact is by visiting them. Frequency of contact is probably related to many factors, such as geographical proximity, cost, and time constraints. More subtle influences may include the pleasantness of the residence (I.D.E.A.S., 1998) and the cognitive status of the resident (Port et al., 2001). Another factor that can influence the frequency of visits is the quality of the relationship between a resident and her family member.

Some residents may have few visits from family members, while other residents have frequent visits. One situation is not necessarily better than the other. Frequent visits may be a source of great pleasure and satisfaction for a resident who enjoys her family, appreciates the socialization, and feels strengthened by direct contact with people she loves. On the other hand, frequent visits may be a source of pain and anxiety for a resident who feels overburdened by the emotional needs of her family, intruded upon by their appropriation of her space, and overwhelmed by the resurrection of old conflicts at each visit. Below are questions to consider when thinking about the impact of family visits.

- How does the resident feel about family visits?
- How do the family members feel about their visits?
- How do family members relate to the staff when they are visiting?
- How do family members relate to other residents when they are visiting?

Family dynamics have a significant impact on how a resident is currently functioning. For example, a son may be able to tell you that his mother had periods of depression in the past whenever her adult children planned long vacations. On occasion this prompted the children to change their vacation plans to look after their mother, causing frustration and resentment. Even now, when this son reveals to his mother that he won't be visiting for a couple of weeks, he fears she will become depressed again.

You might also encounter a resident who relates to her family differently than she relates to other people. For instance, she may be polite and pleasant with peers and staff, but she may be rude and abrasive with her daughter. That kind of difference might be worth exploring in therapy. In every situation, having knowledge of family dynamics can help you understand a resident and guide interventions. Understanding family dynamics also may help you recognize and process transference responses of the resident toward you.

As you learn about a resident's family, one key topic to investigate is how the family was involved in the resident's move to the residence. In most cases residents arrive following a process that has involved many members of the family. You may find it

helpful to know who has been involved and what role they have played, particularly if placement issues figure prominently in the resident's current concerns. Residential placement is an event that can shift or accentuate family dynamics in volatile ways.

“You take care of your own”

Mrs. F has been living in assisted living for six months, and her daughter visits her every weekend. Although Mrs. F understands that she can no longer live at her daughter's house because her care needs have increased, she nonetheless feels resentful about being “shoved out.” She hasn't expressed this directly to her daughter though. “We just don't say those kinds of things in our family,” she says. “Besides, she has her own family, and I don't want to be a burden if she's not willing to take me in.”

In therapy the story comes out that Mrs. F cared for her own aging mother at home until her mother died after a dementing illness. This was difficult work for Mrs. F, as her own health was not that good, and her mother was angry and often physically aggressive as the dementia progressed. Still, Mrs. F felt it was her duty to care for her at home. She explains her dedication by saying, “That's what families do for each other. You take care of your own.”

Mrs. F's daughter has never commented on this family history, nor has Mrs. F discussed her feelings about family obligations. Yet when Mrs. F's daughter visits, Mrs. F is often critical of the residence, the people around her, and even her daughter. Consequently, their visits are uncomfortable for both of them, and they leave Mrs. F feeling exhausted, unsettled, and despondent. There are issues here that make both mother and daughter frustrated, and there are opportunities for intervention.

- Involving family members in treatment

In some cases family members can be helpful throughout therapy. Family involvement may be particularly important in later phases of treatment, as you rely more on environmental resources to support the resident. Below are examples of how family members might be helpful. Family members can:

- assemble a memory book with photographs and mementos;

- increase the number of pleasurable experiences a resident has through visits and outings;
- share biographical information with you and the staff;
- offer suggestions about a resident's personal preferences;
- observe staff to make sure they are following through with staff-dependent interventions;
- assist with therapeutic interventions (e.g., bringing the resident to events, encouraging activity);
- monitor the resident for improvement or deterioration in mood.

Whether you decide to meet with family members and plan strategies with them will depend on a number of factors. One consideration is whether the resident wants you to. She may have reasons (sometimes legitimate, other times defensive) for not wanting you to involve the family. On the other hand a resident may want to discuss issues with her family but may be uncertain how to bring them up.

A second factor is how helpful you think involvement of family will be. Families who are troubled by their own maladaptive patterns may be beyond the help of simple interventions, and involving them in your client's treatment may bring more disruption than gain. The health, cohesion, and flexibility of the family system may influence whether and how you involve them.

A third factor is the availability of the family. Some nursing home residents may not have family or may have family who are distant or otherwise inaccessible. Trying to get them involved may be unrealistic.

And finally, a fourth factor is your own beliefs about how involved family should be in individual psychotherapy. Be aware of a potential bias to respect the resident's privacy by not involving family. Sometimes this is appropriate; sometimes it may impede interventions.

As a final note, staff-family cooperation can be a great asset to the well-being of residents in long-term care facilities. Unfortunately, biased beliefs and institutional barriers can get in the way of collaboration between these important parties. Pillemer and colleagues (1998) have developed a workshop entitled *Partners in Caregiving* to improve communication and cooperation between long-term care staff and family members. Their materials would be helpful if you wanted to undertake a more formal effort to improve relationships between staff and family.

Confidentiality and HIPAA

There are extensive guidelines regarding the sharing of protected health care information under the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA. In your role as a psychotherapist you are probably familiar with the HIPAA guidelines, but we encourage you to think about how the suggestions we make here (and elsewhere in the manual) about involving others in a resident's treatment need to conform to HIPAA principles.

What the system demands of you

Regardless of the system you work with (staff or family), people may turn to you for advice, for answers, for a solution. You may get a referral to see a depressed resident with whom the staff are frustrated and angry. "Get her to come out of his room," they insist. Family members may complain to you that their mother doesn't want to get involved in activities in the nursing home. They puzzle, "She used to be so lively, so involved, but we can't get her to see all the good things here. She could meet new friends, do arts and crafts, things the other people do. Can't you get her to like this place more?" They want (and expect) you to fix the problem.

While the distress of staff and family are important aspects of your work, remember that your primary client is the resident, not staff or family. Likewise, from a systems perspective, you might consider whether it is helpful for you to walk in and provide a solution rather than construct a solution with the help of people who will continue to interact with the resident after therapy is over. It is probably more helpful in the long term if you think of yourself more as facilitator than expert. Enlist family and staff as problem solvers. Get them involved in the process. Use their input and ideas to structure solutions. For example, if you are working with a resident who has unique bathing and showering needs that require some modification of a staff member's routine, you might get that staff member (and perhaps the supervisor) involved in the discussion, acknowledge the difficulty the modification may pose, and seek their help in achieving a solution. If you are working with a resident who is upset because his son visits on an unpredictable and disruptive schedule, you might arrange a meeting where both father and son can discuss the situation with you present as a facilitator. Problems arise within the system that can only be fixed within the system.

Finally, keep in mind that in some cases your involvement may be unwelcome. You may have suggestions for staff and observations for family members that they are not

happy to hear. Don't expect resistance, but be prepared should you encounter it.

Specific questions in assessing the organizational environment

If, after reading the above sections, you want a more structured assessment of the organizational system, we suggest you consider the following outline that is taken from a superb chapter by Rader (1995). Here we simply organize its main points in checklist form, but we encourage you to read the chapter in its entirety. It provides a set of questions formulated to help you think more systematically about the nursing home environment in which you work, focusing on three facets: 1) the organizational environment, 2) the physical environment, and 3) the psychosocial environment.

- **Organizational environment**

Ask for a copy of any manual or materials provided to new employees.

Philosophy

- Does the organization's philosophy or mission statement reflect the importance of resident-centered, individualized care that recognizes the continued generativity of older adults?
- If there is a written philosophy, is it put into practice or is it just words on paper?
- Does the philosophy enhance or inhibit resident autonomy and control?
- Were residents and families involved in developing the philosophy?
- Is the philosophy taught to new employees and included in the staff orientation?
- Do training classes for certified nursing assistants and other staff teach a resident-centered philosophy?
- Are the certified nursing assistants who have been working for many years aware of the philosophy and the changes in practice mandated by OBRA?
- Have they received education and training related to how the OBRA philosophy affects the way they provide care?
- Is there an unwritten philosophy that is stronger than the written one?

Policy and procedures

- Do training manuals provide guidelines for helping staff to approach such issues as restraints? psychoactive medications? timing of ADLs? problem behaviors?

Staffing patterns

Most nursing homes have a greater number of staff on duty during the day, but residents with dementia may become more confused, restless, and distressed in the evening and late night. Does the nursing home...

- Restructure staff patterns so there is more assistance and activity during shifts other than the day?
- Provide permanent assignment of CNAs and other staff to residents with memory problems?
- Pull staff from other units, disrupting the permanent assignment scheme, when short on staff?
- Rely on temporary, agency personnel when they are short staffed? (These individuals are less likely to be familiar with the residents.)

Structure of the day

Many residents with dementia benefit from having a daily routine with some degree of predictability to it. This does not mean their schedule is rigid though; there must be leeway to change routine in response to the resident's needs and wishes.

- Are residents encouraged to sleep, eat, and get up in their familiar daily patterns, or is there pressure to conform to a schedule established by the staff or residence?
- Is there a predictable, comfortable rhythm and flow to the day for residents?
- Are periods of structured activities alternated with periods of quiet and rest?
- Are residents able to structure their day as they wish, even into the evening hours?

Staff support and education

An organization must respect its staff if it expects them to respect the residents. Staff support is a sign of respect.

- Do staff members have access to resources that enhance their caregiving skills, such as books, consultants, and educational programs?
- Are staff members encouraged to attend workshops by having paid in-service days and workshop fees paid by the residence?
- Do the supervisory staff have expertise in staff management?
- Are provisions made to provide support, debriefing, and problem solving for staff members who have been involved in aggressive/ combative situations with a resident?

- Are in-services routinely offered that explore ways to defuse and prevent aggression and other difficult situations?
- Are mental health consultants available to the staff for problem solving and education?
- Is there an employee assistance program available for staff members experiencing an emotional or financial crisis?
- Are the numbers and expertise of the staff generally sufficient?

Equipment and supplies

- Is equipment up to date?
- Are supplies (e.g., sheets, towels, personal care items) available?
- Are administrators and staff aware of the latest innovations in care equipment?
- Is there a plan for systematically upgrading equipment?
- Is the current equipment in good working order?

● Physical environment

Personalization

Providing opportunities to display personal objects as symbols of past adventures, roles, and connections helps an individual stake out a territory and maintain his/her identity, and provides orienting cues for a person who is confused.

- Is the environment personalized appropriately for the resident?
- Are personal items safe, or are they at risk for becoming lost or stolen?
- Can residents bring in their own beds, chairs, pictures, and other furniture?
- Can residents put pictures on the walls and personalize bedding and window coverings?

Noise level

Residents may have difficulty screening out or escaping from noise.

- What is the usual noise level on the unit during activities, change of shift, at night?
- Have any attempts been made to decrease the noise level?
- How is the intercom system used? Have ways to eliminate or decrease its use been explored?
- Are music and tapes of the resident's choice used routinely and

- therapeutically to create a relaxed, quiet environment?
- Are staff shoes noisy?
 - Are carts, wheelchairs, and other equipment in need of maintenance to decrease noise?
 - Is a TV (or TVs) contributing noise and confusion to the environment?
 - Do open windows bring in pleasant or unpleasant sounds?

Lighting

Older individuals need approximately three times more light than a 20-year-old.

- Is the lighting in halls adequate?
- Is there sufficient light for reading?
- Are the fluorescent lights working properly?
- Are desk lamps and table lamps available to provide extra lighting, soften the effect of fluorescent bulbs, and create a homelike appearance?
- Do the residents have adequate lighting in their rooms?
- Is furniture placed so that natural light can be used?
- Do windows and window coverings let light in but minimize glare?
- Are curtains used at night to reduce reflection in windows?

Floor coverings

- Do the residents have the appropriate shoes or walker for their gait and floor covering?
- Is the floor so shiny that the glare may be hard on residents' eyes or create reflections that confuse them?
- Are transitions from one floor covering to another easy to navigate and safe for residents?

Furniture

- Is the furniture the right size and arrangement for residents' individual needs?
- Do residents' feet firmly touch the ground when seated at the bedside?
- Are there unstable objects or furniture with wheels in the environment that need to be removed or made safer for support?
- Are a variety of different sizes of chairs available?
- Does the arrangement of furniture in common areas promote socialization?
- Are toilets and commodes the right height?
- Are drawers easily opened?

Seating and mobility devices

- Are wheelchairs a potential source of discomfort?
- Has an interdisciplinary team assessed seating and mobility needs?
- Are different sizes and shapes of chairs available, and can they be custom fitted as needed?
- Are a variety of walkers available?
- Are bed heights adjustable?
- Are resident shoes safe and comfortable?

Way-finding cues/landmarks/signs

- Is the resident's room personalized enough to provide orientation cues?
- Are there cues that distinguish one unit from another?
- Do signs direct you to where you want to go?
- Are letters on signs printed large enough and spaced well?
- Are signs located at the right height?
- Are rest rooms visible from public seating areas?
- Does the color of the toilet contrast with the color of the floor or back wall, so that it is clearly visible?

Activity or stimulation level

The mood of the unit, particularly at shift changes, can be reflected in anxiety or restlessness in the residents.

- Is there a relationship between unit activity level and resident behavior?
- Can things be done to create a less chaotic, calmer environment?

Space for privacy and socialization

- Are there spaces and opportunities for residents to have privacy?
- Does the arrangement of furniture promote interaction?
- Can the schedule of activities be adjusted to create private times for residents who have roommates?

Safety and security

- Are areas of prohibited access secure?
- Have resident areas been assessed for safety?
- Are there areas where residents can safely roam, touch, and explore?
- Is there a staff committee to monitor and solve safety issues?

- Psychosocial environment

Communication skills of resident

It is important to tailor communication to match the abilities of the resident.

- Do residents have communication difficulties, and if so, of what type?
- Does the way the staff and others communicate to residents inhibit their ability to function at the highest level of independence?
- Are family members invited to teach staff about communicating with the resident?
- How skilled are staff at verbal and nonverbal communication?
- Are staff verbal and nonverbal messages congruent?

Staff attitudes

- Are the staff (at all levels) satisfied and committed to their jobs?
- Do the staff generally perceive residents as human beings to care for or tasks to accomplish?
- Do staff view difficult behavior as a problem or as reflecting an unmet need?
- Does the resident's behavior vary with different staff members who have different attitudes?
- Are staff willing to look at ways of changing their behaviors and approaches?
- Do staff seem to "blame" the resident for difficult behavior, or do they look for causes of problems outside the resident?
- Do staff talk about residents in their presence?
- Do staff tease residents or make fun of behavioral symptoms?

Nurturing healthy relationships

- Are staff aware of ways to support residents' autonomy?
- Is sitting and talking to residents viewed as part of the job or as a way to avoid work?
- Do managers role model appropriate ways of relating to residents?
- Does the philosophy of care recognize equality in the relationship between staff and residents?

Staff approaches

- Do staff members identify specific behavioral symptoms?
- Do staff members explore internal and external factors in determining causes of behavior?
- If the cause cannot be eliminated, what alternative "tools" or approaches are

- used to decrease the behavior?
- Is there a systematic plan for addressing specific problem situations?

Activities

- Do staff ask cognitively intact residents what they enjoy?
- Do staff pay attention to the response of cognitively impaired residents to gauge their positive or negative reaction to an activity?
- Do staff modify activities to ensure they are consistent with previous interests?

Family support and education

- Does the residence provide educational opportunities, emphasizing to the family that their input is important?
- Do staff ask the family to provide information about hobbies and interests?
- Do staff ask the resident and/or family about personal care preferences?
- Is there a support system for families?
- Are families encouraged to remain active in caregiving activities?

Chapter 5 ~ Establishing a Treatment Plan

Effective psychotherapy is guided by clear treatment goals. Your work with residents will be more focused and productive if you work toward specific objectives. Treatment goals also are important because they allow you to document and monitor the symptoms you are treating, the strategies you are using, and the progress the resident is making. That kind of documentation is becoming increasingly important in an era when justification of treatment and accountability are priorities for the organizations that pay for treatment. It will benefit both the resident and you to have a clear treatment plan that guides your work.

In this chapter we offer basic information about treatment planning as it relates to REM, and we discuss one model that we have used for structuring treatment plans. More detailed guidance can be found in other excellent resources on treatment planning, including a general resource by Jongsma & Peterson (1995) and information about treatment planning for older adults by Frazer & Jongsma (1999). Of course the residence where you work or the organization you work for may have guidelines about treatment planning that you may need to follow.

When to develop the treatment plan

The timing of when to develop the treatment plan will vary from case to case. A resident with minimal cognitive impairment, clear antecedents to her depression, and unambiguous goals may be able to work with you on setting treatment goals at the end of your first session. More commonly, you and the resident may meet for 2-3 sessions before you have a thorough understanding of her issues and can together articulate her goals for therapy. As we mentioned in an earlier section, to make sure you have a solid working relationship with the resident you may postpone a detailed discussion of treatment goals in the first session so you can concentrate on establishing rapport. In general, though, you should be able to devise a thorough treatment plan by the end of your third session. Naturally, the treatment plan is open for modification, and you may find yourself adapting it as the clinical picture becomes clearer or as some goals are attained and others become more primary.

Who contributes to the treatment plan

As the treating clinician you have principal responsibility to devise and write the treatment plan. Having said that, identifying problems and goals is a process that will involve other people, most notably the resident herself. The degree to which a resident will be able to participate in the treatment planning process will depend on her level of cognitive impairment, among other factors. Insight, judgment, and memory are critical

skills in the process of identifying problem areas and brainstorming about solutions, and residents with more advanced dementia may not be able to engage very well in that process. Nonetheless, it is still important to discuss treatment goals with residents who have significant impairment, even if the final articulation of those goals comes mostly from you.

It will be rare that a resident will have referred herself for psychotherapy, so it's unlikely that a resident will come prepared with a list of specific objectives she would like to accomplish in therapy. More likely, a physician, social worker, certified nursing assistant (CNA), or family member will identify a need for a referral because of some change in behavior they have noticed. In this circumstance the staff or family member may have ideas about what the treatment goals should be. Their input is valuable because staff and family may have a perspective on the resident that the resident cannot have about himself. For example, the resident may not be aware that she is not talking to her table mates at meals, but that may be apparent to the staff who are in the dining area. On the other hand, be aware that staff and family also can have a biased perspective on treatment goals.

Staff and family may desire the resident to be a certain way, but that might conflict with how the resident wants to live. For example, staff may want a resident to attend a group crafts session in the morning, but the resident may be happiest when she has the opportunity to stay in bed and peruse the newspaper at her leisure.

A concerned family member might comment, "I think my mother should be spending more time going to social events, participating more, getting herself involved with arts and crafts and music. She'd feel a lot better if she just got out of her room and did more." That may or may not be true. And it may or may not be what the resident thinks is a problem or what you identify as a target for therapy. Similarly, a staff member might say, "She's always at the nurses' station complaining or asking questions, getting in our way, and sometimes she's downright nasty," thinking that an appropriate treatment goal might be to "improve her attitude," meaning "get her to leave us alone." While this information is useful, it might suggest a different goal to you, such as helping the resident become more appropriately assertive with staff. Foremost in your treatment plan should be the best interests of the resident.

Treatment goals and paternalism

What do we mean by "best interests?" And who decides what a resident's best interests are? One of the most delicate aspects of your work will occur when the desires of the resident conflict with what others (including yourself) believe is in her best interest. For example, a resident may say that she prefers to stay in her room most of the day, but you may see that as maladaptive behavior for the resident, behavior that is evidence of her depression and further contributes to it. You may think that a reasonable treatment goal for the resident is to spend less time in her room, even though she says she wants to spend time there. What should you do in that kind of situation? As a clinician, you have the professional knowledge to make a careful analysis

of a resident's situation and develop a treatment plan that will benefit the resident's mental and physical well-being.

A resident with moderate cognitive impairment may be even less able to consider her circumstances rationally and identify helpful treatment goals. The opinions of residents with significant deficits in insight, judgment, and reasoning may more often be at odds with your own treatment recommendations. The issue here, again, is balancing the resident's desires with what you think may improve her health and functioning. For residents with moderate dementia the major responsibility for setting goals may be yours. At the same time, try to keep your goal setting as collaborative as possible. Perhaps the treatment plan can contain a compromise or a couple of different goals that reflect the desires of the resident and your thoughts. At the very least, share your thoughts with the resident and let her know what you are planning and why.

How to develop a psychotherapy treatment plan

A good treatment plan is based on a thorough understanding of the resident, her circumstances, her needs and desires. A thorough biopsychosocial assessment is a prerequisite to constructing the treatment plan. You are unlikely to have all the information you will need by the end of the first session. It takes time for the resident to tell her story; it takes time for you to review charts, talk with family members, and confer with staff; and it takes time for you to piece all the information together into a comprehensive picture.

Your original referral may be a good starting point for identifying treatment goals. Perhaps the referring physician has mentioned a particular symptom or cluster of symptoms that you can focus on, or a behavior that has become problematic for the resident. The results from an earlier evaluation—or your own evaluation—with the resident may have made clear what should be the focus of therapy. Consider what the resident has mentioned in your conversations. To what does the resident attribute her lowered mood? What does she think would make her feel better?

Your process for developing treatment goals should include an examination of the resident's pattern of depressive symptoms. When thoughts of worthlessness and guilt are prominent, explore the content of those cognitions. When passive suicidal ideation is present, examine the drive behind the wish to be dead; is it related to poor health, functional limitations, not wanting to be a burden? When sleep is disrupted examine factors that might contribute such as a loud roommate, extraneous noise at night, or poor sleep hygiene. When poor appetite and weight loss have been identified as a problem, think about food preferences and possible interventions that might involve dieticians.

Talk with the staff about changes they have noticed. When a CNA mentions that a resident is spending more time in her room, this may be an indication that interventions focused on increasing social networks and activities may be helpful. When an activity therapist recognizes declining interest in craft activities that the resident previously enjoyed, this may guide your attempts to increase her pleasurable events. Environmental

personnel may notice a decline in how the resident is keeping her room, which might signal a change in mood and offer a treatment goal you can discuss with the resident. As suggested by each of these examples, you should be clear about whether the resident's symptoms have cognitive or affective origins.

Think about possible sources of negative influence on the resident. Are there institutional policies that interfere with the resident's ability to engage in activities she enjoys, or when and how she enjoys them? Have you noticed that after visits from a particular family member the resident seems more upset and withdrawn? Has the resident expressed frustration with sensory impairments that prevent her from enjoying activities? Does the behavior of other (noisy, agitated, disruptive) residents interfere with a peaceful living environment? Answers to these questions may provide some insight into treatment goals.

A good treatment plan includes specific objectives that have two characteristics.

- 1) They are realistic. That is, the objectives should be useful and practical. They should reflect what you truly hope to accomplish during psychotherapy. If you think it's reasonable that a resident will be able to attend one social event per week, include it in the treatment plan. But don't overreach and plan that the resident will attend three group meetings, a concert, and card club if that's something the resident can't possibly do. Small, reasonable goals with a good chance of success are probably more helpful than grand changes (at least at first).
- 2) They are measurable. That is, an outside observer could judge whether progress is being made and whether the objective has been attained. If you want to be able to evaluate the outcome of your therapy you need to have concrete, observable objectives that you can track. For example, an objective to increase social participation may be monitored by tracking attendance at group meals, events, or casual conversations with other residents or family. If your goal is to increase self-esteem, you'll need to develop a plan for how to monitor changes in self-esteem over the course of therapy, perhaps by tracking negative self-statements in session. If you hope the resident's sad mood will lift, you may want to administer a one-item mood assessment at the start of each meeting.

In sum, your treatment plan should reflect a circumscribed set of objectives that can be tracked via concrete behaviors.

A sample approach for constructing a psychotherapy treatment plan

In recent evaluations of REM treatment we have used a method for treatment planning based on Goal Attainment Scaling (GAS), a technique for developing and quantifying goals in psychotherapy. The idea behind GAS is to devise broad treatment

goals and specific treatment objectives that can be tracked using a simple rating scheme. Some form of this idea has been around for a while (see the original article by Kiresuk & Sherman, 1968, which offers an excellent description) and continues to be used by contemporary researchers (see Rockwood, Stolee, Howard, & Mallery, 1996, for an example).

We used the GAS framework because it yields quantitative information that can be analyzed statistically, but it is useful outside of a research context because it encourages the articulation of clear treatment goals and provides a method for documenting progress toward those goals. This is only one approach. You may prefer a different strategy.

Below is an example of a treatment plan for a depressed resident with moderate cognitive impairment.

CASE #1: Mrs. Clarke is an 85-year-old woman who has been in the nursing home for three years. She has significant memory deficits, and is disoriented and confused at times. Although increasing agitation has marked recent episodes of disorientation, she is generally pleasant and can be calmed easily. A recent MMSE evaluation yielded a score of 19 out of 30. Previously quite social, she has been spending more time in her room, refusing to eat with others, removing herself from the exercise group on the unit, which she used to enjoy, and declining invitations to religious services. She recently started to bemoan her isolation, which she relates to her belief that she is uninteresting and a “stupid failure.” After two meetings, the therapist and Mrs. Clarke developed three goals on which to focus during the psychotherapy. The therapist discussed the goals in general terms with Mrs. Clarke, who acknowledged that she wasn’t feeling herself. Those goals, and the concrete behavioral objectives associated with them, are outlined below.

Goal #1: Resident will feel less isolated and disconnected from social contacts.

Goal #2: Resident will have improved self-esteem.

Goal #3: Resident will be less anxious.

Rating	Goal #1			Goal #2			Goal #3		
	0	1	2	0	1	2	0	1	2
+3 surpassing the goal	Pt. initiates, generates, and sustains new relationships			Pt. independently seeks opportunities that bolster self-esteem or enhance positive aspects of self			Pt. demonstrates no significant signs of anxiety for one week		
+2 achieving the goal	Pt. identifies people with whom she has meaningful relationships			Pt. is able to articulate positive things about herself			Pt. has no more than 2 episodes of observable anxiety in one week		
+1 improving but not achieving the goal	Pt. makes less intense and less frequent statements about "being alone"			Pt. makes less intense and less frequent negative statements about self			Pt. has 3-4 episodes of observable anxiety in one week		
0 baseline; no change	Pt. experiences depressed mood related to feelings of being "alone"			Pt. has low self-esteem as evidenced by negative self statements			Pt. experiences nearly daily periods of anxiety and agitation related to environment and social demands		
-1 mild deterioration	Pt. continues to withdraw from productive and pleasurable activities			Pt. displays increase in negative statements and feelings of worthlessness			Pt. repeatedly goes to nursing desk; or displays increase in physical symptoms of anxiety		
-2 moderate deterioration	Pt. refuses to go to meals and spends long periods of time in room			Pt. refuses to engage in social activities for fear of failure			Pt. becomes immobilized by anxiety; withdraws from normal routine		
-3 severe deterioration	psychiatric hospitalization			psychiatric hospitalization			psychiatric hospitalization		

Each goal includes a list of objectives or potential behaviors that indicate whether the resident is improving or declining. Each objective is associated with a numeric rating, -3 to +3. (Traditional GAS uses a five-point rating scale, -2 to +2; we have used a seven-point scale to provide greater sensitivity to change.) The resident's current status always defines the baseline (rating = 0). That is where the resident is at the beginning of treatment, and that is where she would remain if there were no change during

treatment. Improvements are noted in relation to baseline behavior:

- +1 = behavior signifies some improvement but not actually attaining the goal
- +2 = behavior signifies achieving the goal
- +3 = behavior signifies surpassing the goal.

So, the +1 behavior indicates at least some progress in therapy, +2 behavior represents what you think the resident can reasonably accomplish with successful psychotherapy; +3 indicates psychotherapy that exceeds your expectations. Potential decline in the resident's behavior also is described:

- 1 = behavior signifies mild deterioration from baseline
- 2 = behavior signifies moderate deterioration
- 3 = behavior indicates severe deterioration (we have used psychiatric hospitalization as an indicator of the most severe decline).

Another feature of the GAS technique appears at the top of the example. This is a scale (0-2) where you can indicate the importance of each goal. This rating may be useful if the priority of goals changes over the course of therapy. As an example, a resident's weight loss and disinterest in food might be the most important goal when you start working with her, but concerns about estrangement from a sibling might gain preeminence as her eating problems stabilize.

At the conclusion of each session you can discuss with the resident how she thinks she is progressing toward her goals. Circle the rating that best describes where the resident stands. You may even construct a graph of ratings to document progress. That kind of feedback could be shared with the resident or staff. Circling the resident's status on each goal provides an easy way to track progress or deterioration. This form can be filled out, photocopied, and then completed at the end of each session. This might be done along with the resident at the conclusion or beginning of each session.

Below is another example of the GAS approach to treatment planning.

CASE #2: Mr. Gordon is an 72-year-old gentleman who was referred for treatment when staff noticed a gradual decline in his social involvement on the unit. He was difficult to roust from bed in the morning, stayed in his room for most of the day, and responded to conversation from staff with only brief responses. Upon initial evaluation he demonstrated moderate depressive symptoms including anhedonia, hypersomnia, decreased appetite, and feelings of worthlessness and futility. His score on recent administrations of the MMSE averaged 23 out of 30, suggesting mild cognitive impairment. In discussions with his therapist, Mr. Gordon acknowledged that he was upset by his daughter recently moving out of the area. Visits with his daughter that once had been a source of great satisfaction now were to

be much less frequent. With the loss of that social contact, Mr. Gordon had lost interest in pursuing his usual social interactions as well. Previously very active in activities, Mr. Gordon said he saw little purpose to these endeavors and he didn't see what he had to add, "an old, useless bull like me." Mr. Gordon and his therapist developed three treatment goals and the following objectives.

Goal #1: Reestablish social activities and connections.

Goal #2: Increase positive feelings about himself.

Goal #3: Increase pleasurable experiences.

Rating	Goal #1			Goal #2			Goal #3		
	0	1	2	0	1	2	0	1	2
+3 surpassing the goal	Pt. initiates daily conversations with other residents			Pt. makes spontaneous positive self-statements in session			Pt. participates in 2-3 pleasurable activities/week		
+2 achieving the goal	Pt. initiates phone calls to friends/family			Pt. identifies current strengths and abilities			Pt. participates in 1 pleasurable activity/week		
+1 improving but not achieving the goal	Pt. has telephone hooked up			Pt. identifies past accomplishments and reports feeling proud of them			In session, pt. identifies pleasurable activities		
0 baseline; no change	Pt. spends substantial time in room alone; initiates few contacts with family, friends, or other residents			Pt. reports feelings of worthlessness, uselessness, wish to die			Pt. reports few/no pleasurable activities		
-1 mild deterioration	Pt. spends 100% of time in room but can be encouraged to come out			Pt. reports increased feelings of worthlessness, wish to die			Pt. refuses all offers of pleasurable activities		
-2 moderate deterioration	Pt. refuses clinic appointments, meals, leaving room			Pt. reports active suicidal ideation			Pt. refuses psychotherapy		
-3 severe deterioration	psychiatric hospitalization			psychiatric hospitalization			psychiatric hospitalization		

Assessing progress toward treatment goals

In addition to the process outlined above regarding the treatment plan, you may want to include additional measures to monitor specific aspects of your work with the resident or specific features of the treatment plan. For instance, you may want to include periodic administration of an objective depression questionnaire to track the resident's depressive symptoms.

There are a number of instruments available for tracking psychotherapy outcomes, and many of those instruments have been either designed with older adults in mind or modified for use with older adults. Some even have been designed specifically for use with older adults who are depressed and/or demented.

- To assess mood
 - Cornell Scale for Depression in Dementia (CS; Alexopoulos et al., 1988)
 - Dementia Mood Assessment Scale (DMAS; Sunderland et al., 1988)
 - Geriatric Depression Scale (GDS; Yesavage, Brink, & Rose, 1983)
 - Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)
 - Hamilton Depression Rating Scale (HDRS; Hamilton, 1967)
 - Rosenberg Self-Esteem Scale (Rosenberg, 1965, 1979)

- To assess anxiety and agitation
 - Cohen-Mansfield Agitation Inventory (CMAI; Cohen-Mansfield, Marx, & Rosenthal, 1989)
 - Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990)
 - State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Luschene, Vagg, & Jacobs, 1983)

- To assess social involvement
 - Activity Participation Scale (APS; Lawton, Van Haitsma, Klapper, Kleban, Katz & Corn, 1998)

- To assess physical and health functioning
 - ADL Index (Katz et al., 1963)
 - Multidimensional Assessment Instrument (MAI; Lawton, 1988)
 - Multidimensional Observation Scale for Elderly Subjects (MOSES; Helmes, 1988)

- To assess cognitive functioning
 - Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975)
 - Mental Status Questionnaire (MSQ; Kahn, Goldfarb, Pollack, & Peck, 1960)
 - Dementia Rating Scale (DRS; Mattis, 1973)
 - Short Portable Mental Status Questionnaire (SPMSQ; Pfeiffer, 1975)

Other areas of assessment that may be important to pursue with some clients include alcohol use, sleep disturbance, psychosis, delirium, sexual dysfunction, pain, family relationships, and competency. For further information about assessment with older adults, we refer you to excellent resources such as those by Lawton (1994) and Lichtenberg (1999).

Chapter 6 ~ The First Session: Education and Orientation

In your first session you can educate the resident about the process of psychotherapy and what he can expect in your meetings ahead. Preliminary education may be especially important when working with older clients, who may be less familiar with (and more wary of psychotherapy) than younger clients. Research has shown that when psychotherapy clients are given information about therapy before it begins, clients are more likely to report improvement in symptoms within the first month of treatment (Zwick & Attkisson, 1985). In addition, clients are less likely to miss appointments or drop out of therapy (Sherrill, Frank, Geary, & Stack, 1997; Walitzer, Dermen, & Connors, 1999; Wilson, 1985). Explaining the purpose and format of therapy seems to help “cement” a client’s commitment to the process.

Equally important, from the moment you sit down with the resident you need to begin to establish a comfortable, open, and trusting working relationship. The tone you set during this first session can have a powerful influence on the entire course of therapy. In this first session the resident will learn by watching your behavior who should do the talking, what the appropriate topics for discussion are, and what level of formality is expected. The resident also will make a quick judgment about how comfortable he feels with you, how open he can be with you, how much he trusts you, and how much he thinks you and the therapy can help him. These impressions are formed very quickly, and it’s up to you to make sure the resident has the right impressions from the start.

A comment on informed consent

The ethical practice of psychotherapy rests upon obtaining informed consent (APA, 1992, Section 4.02). Different long-term care facilities handle informed consent in different ways. In some facilities residents sign a blanket consent form for all services, and psychotherapy may be included in that blanket consent. In other facilities that may not be the case, and it may be up to you to obtain informed consent. How that is accomplished may depend on residents’ level of cognitive impairment and the severity of depression. Residents who are competent to make their own decisions regarding health care treatment are capable of giving or refusing consent for psychotherapy. Residents who are not competent to make their own health care decisions may require consent obtained from a legal

guardian or next of kin. If the resident has signed a blanket consent form or if you obtain consent from a guardian, it is still important to get verbal assent from the resident for his participation in psychotherapy.

An excellent book of practice guidelines on the assessment of competency and capacity in older adults was created by the Department of Veterans Affairs (1997). A number of brief instruments are available for assessment of competence. As an example, Pruchno, Smyer, Rose, Hartman-Stein, and Henderson-Larabee (1995) published a brief instrument for use with older adults in long-term care. Basic guidelines about informed consent for psychotherapy can be found in Koocher & Keith-Spiegel (1998) and Pope & Vasquez (1998).

Below we outline the goals of the first session. Although the topics are presented numerically, the order in which you introduce these topics to the resident is up to your discretion.

Goals of the first session

- ① review the reason(s) for referral
 - ② provide education about depression
 - ③ provide education about psychotherapy
 - ④ provide information about yourself
 - ⑤ clarify confidentiality, fees, and scheduling
 - ⑥ instill hope and positive expectations for success
 - ⑦ build rapport with the resident
-

① Review the reason(s) for referral

Most referrals for the treatment of depression in long-term care facilities are prompted by observations of the staff. Consequently, the resident may not have a clear understanding of why you are coming to see him. In addition, some time may have passed between his initial assessment (presumably when therapy would have been offered to him) and your first meeting. It may be helpful to remind him who suggested that you meet and why.

Therapist: Your doctor has been concerned about how you've been feeling recently, and she asked if I would talk with you about it. She was worried that you don't seem to be eating as much as usual. Seems that you've lost some weight over the last few weeks. Some of the staff also noticed that you don't seem to be involved in activities as much as you used to be. I'm here to talk to you about some of those things to see if you and I, together, can figure out some ways to help you feel better.

In this example note that the therapist reminds the resident about who has expressed concern about his mood and exactly what symptoms were cause for concern. If possible, request those making referrals to you to inform the resident about the referral so the resident has the opportunity to refuse services before you visit or is not surprised when you make your first contact.

② Provide education about depression

A resident might not know anything about depression beyond his personal experience. For instance, he may not know that depression is common in older adults living in nursing homes, by some estimates affecting as many as 40 % of all residents (Borson & Fletcher, 1996). During the first session you can normalize the experience of depression by sharing information about its prevalence.

Older individuals also may be less likely to interpret their feelings and symptoms as depression. They may be less likely than younger adults to think of their depressive symptoms or problems as psychological. Instead they may look for physical reasons to explain their symptoms. So, when a resident complains of disrupted sleep you can help him understand that his poor sleep may be a manifestation of a mood disorder. Similarly, a resident may be aware that he is spending more time in his room alone, but he may not attribute his social withdrawal to depression. You can make that explicit connection for him. Here is an example of general information about depression that you might provide.

Therapist: Sometimes emotions can affect your body. Let me give you an example. If you've felt nervous before you probably noticed that your heart beat faster, your stomach felt fluttery, and maybe you even started to sweat. What was happening was that your thoughts and feelings were causing your body to react. Something similar can happen when you feel depressed. When some people are depressed they lose their appetite. Some people also notice that their sleep changes. They might wake up often throughout the night or wake up earlier than usual. Or they may feel tired all the time and want to sleep a lot more than they usually do. These

are examples of how what's going on in your mind can affect your body.

A resident might describe other physical symptoms that can be reinterpreted in terms of depression.

Resident: My back has been hurting me for weeks, and nobody has been able to do anything about it. Are you going to help me with my back pain?

Therapist: Well, I may not be able to make your pain go away, but sometimes when people are in pain it starts to affect other parts of their life. For instance, the pain may make it difficult for you to do the things that you used to like doing. Or it might keep you awake at night. And putting up with that kind of pain can make you feel frustrated and discouraged.

Resident: Yeah, it keeps me from taking walks and I can't get a good night's sleep. I'm cranky with people more than I ever have been before, and I'm feeling like it's just no good, nothing's going to help me.

Therapist: You start to feel like there's no relief possible, that things aren't going to get better, so why bother.

Resident: Yeah, I might as well just stay in my room. And I don't want to force other people to be around somebody who is nasty.

Therapist: That feeling of discouragement is a symptom of depression we can work on together. Your pain may not go away entirely, but I may be able to help you handle it so it's less bothersome to you.

Amotivation and anergy are common symptoms in both depression and dementia, and you may find it challenging to get the resident involved in therapy at all. When you go to find a resident for your session you may be met with a number of excuses: "I just don't feel like it," or "I'm too tired to talk with you today." These comments are common and may reflect a decreased interest and energy for participating in what can be an effortful endeavor. You can address this during the first session as well.

Therapist: Sometimes you may feel like you don't even want to keep our appointments. You might feel too tired. Or you might feel like you don't want to bother talking. Those are common feelings in people who are depressed, and they are feelings we need to help you overcome. When you feel tired and uninterested, that's exactly the time when we need to discuss what's happening. I'll warn you now that there may be times when you don't want to

talk with me. At those times I'm going to encourage you to keep your appointments so we can work on those feelings.

The National Institute of Mental Health publishes a brochure entitled, "If You're Over 65 and Feeling Depressed: Treatments Bring New Hope." You may want to distribute a copy of that brochure to some residents.

③ Provide education about psychotherapy

There are a number of issues related to psychotherapy that you might bring up in this session. Here are some common topics about which you can educate the resident.

- Normalize being in therapy

Some older individuals believe that only "crazy" people need or can benefit from therapy. In this session you should approach this issue directly by normalizing therapy.

Therapist: I'm here to help you with some of the very real problems you are having. No one thinks that you are crazy or mentally ill. Many people find that talking with someone can help them get through difficult times. Psychotherapy can help people get back to living happy, productive lives and feeling good about themselves.

You might draw an analogy between psychotherapy and other treatments with which the resident is familiar:

Therapist: The work you and I do together is going to help your mind and your spirits, just like other treatments you receive here help your body. You have respiratory treatments to help with your breathing or OT to help with your strength. Our time together is another kind of treatment. This one is designed to help you feel better about yourself and your life.

- Clarify the therapeutic relationship

You can help the resident understand how the therapeutic relationship differs from other relationships. You need to be clear that your interactions with the resident will be different from those he has with his physician, social worker, and nurses. Although you are part of the treatment team, your role as a psychotherapist is unique. You will be helping the resident deal with depression and not other physical and

environmental concerns. (Those concerns may be related to depression, though, and you may find yourself working on interventions that address physical and environmental issues.) You won't usually give advice or solve problems for the resident, but you will help the resident think about his situation and ways to improve it.

Your relationship with the resident also is different from those he has with family members or friends. Your role is to listen and help the resident understand himself better, but the relationship is not mutual as in other informal relationships. You won't be talking much about yourself, and the topics you discuss are, for the most part, confidential.

Residents may have more specific questions about how or why therapy works. You can provide an answer that does not go into great theoretical depth but highlights some of the key mechanisms of therapeutic change. Here are some elements of psychotherapy that you might share:

- Having a chance to talk with someone and get things off your chest can bring relief.
 - Talking about situations out loud can help you think about them clearly and come up with possible solutions.
 - A skilled listener can be objective about a situation and help you solve problems.
 - Psychotherapists are trained professionals who can help you understand your thoughts and feelings.
 - A therapist familiar with the nursing home and the staff can help you figure out how to make your life here more satisfying to you.
- Clarify what goes on in psychotherapy

Emphasize that therapy is collaborative. The two of you will be working together to set goals. A resident may be accustomed to having other professionals do things for him, treat his problems while he passively receives the treatment. You'll want to emphasize that the resident is an essential player in psychotherapy. You are not going to do therapy *to* him; you will be doing therapy *with* him.

Also be explicit about what you, the therapist, will and will not do. You will meet him on a regular basis. You will listen to what he has to say. You will help him set and work toward goals. On the other hand, you will not address specific physical problems. You will not regularly do things for him but instead will help him think about how to get the things he needs.

Therapist: The conversations you and I have may be different from what you're used to with your doctor. You and I are going to be working together to improve how you're feeling. You're the expert on you. You know yourself better than anyone else, and you can help me understand how you are feeling and how you would like your life to be. What I can do is share what I know about emotions, problems with living, and human psychology. Together we can combine what we know to help you feel better.

- Discuss the proposed structure and course of therapy

Some residents benefit when you lay out the terms of therapy from the outset. You set clear expectations, and they have a good idea about what's going to happen. Here's an example of what you could say to introduce how the therapy will work:

Therapist: We'll be meeting for approximately 12-16 appointments, depending on how many you and I feel you need. At the beginning of therapy I'd like to meet two times a week, for about half an hour at a time. After that we may meet less often, maybe once a week, depending on how things are going. As you start to feel better we'll talk about how many more appointments you need, and we'll set a date for our last appointment. This is flexible, and we can meet until we're both comfortable that you feel better and can stay better.

With most residents it is important to make clear that psychotherapy is a time-limited endeavor. Make the point that therapy is expected to end (see the section on Termination). This reinforces the idea that this is a focused intervention that requires effort because it's not going to last forever.

Early in this first session you need to feel out with the resident how much information about the structure and purpose of psychotherapy will be most beneficial. With knowledgeable and receptive residents you may be able to talk openly about everything we've mentioned so far, and they may welcome your offer to help them. With residents who are more guarded or residents who have been referred for therapy without their knowledge, your task is more complex. With this type of resident it may be useful not to focus on the mechanics of treatment right at the beginning. Instead you might explain the purpose of your visits in more general terms and spend more time on establishing rapport with the resident:

Therapist: Your doctor has been concerned about how you have been feeling recently, and he asked if I would talk with you about what's been going on. I thought I would drop by and see how you were doing. Sometimes it feels better just to talk about what's on your mind, and I'm here to listen and help you in whatever way I can.

When a resident rebuffs your offer of assistance, one strategy is to accept the refusal but return a couple days later to offer again. In some instances, consistent, gentle offers of help in which you express your concern about the resident and your willingness to listen may be essential groundwork that enables the resident to accept your assistance. In this less direct approach you may postpone discussion of some of the mechanics of therapy until the second or even third session, using your early appointments to solidify the therapeutic bond and get the resident engaged in the process. Too much information too quickly, without adequate attention to establishing a solid working alliance, can alienate the resident and prevent you from being of much help.

Of course, you'll need to keep in mind informed consent. It's not ethical to start therapy without obtaining informed consent, but you can be flexible with the official start of therapy. Try to be as clear as possible with residents about why you are visiting but be prepared to postpone detailed discussion about the psychotherapy process in some cases.

Discussing the duration of therapy is another issue that needs to be handled with care. With some residents it is important to be clear from the outset about the duration of treatment. Awareness of the number of sessions left can motivate them to use their therapy sessions efficiently. Likewise, with residents who are more dependent you may have a sense that it is important to mention termination early in the course of therapy and with more emphasis to prepare them for your eventual departure. Other residents may be put off by statements about the limited nature of the therapy. Their thought may be, "Why should I bother opening up to this person if they're just going to up and leave me anyway?" Here again you may choose to share specific information about termination at different times, depending on the resident.

A book by Kovel (1976) includes a section on questions therapists should be prepared to answer when introducing psychotherapy to new clients. A sample of questions includes:

- Who will know what we talk about?
- How will I know if therapy is working?
- What about cost?
- Will this fix me permanently?

④ Provide information about yourself

Residents may ask about your qualifications, background, and experience treating clients like themselves. More often they will not ask, so you need to take the initiative to provide this information. You might consider mentioning:

- your credentials (e.g., Ph.D., M.A., L.S.W., R.N.)
- your position (e.g., social worker, nurse, psychologist)
- your previous experience working with older, depressed individuals
- your familiarity with the long-term care environment
- your experience observing other people benefit from treatment.

Residents may appreciate the opportunity to learn some personal information about you, more than you might normally disclose with younger clients. They might ask whether you are married, if you have children, where you live, and how long you have worked at the residence. Older individuals may use personal questioning as a way of establishing a normal, friendly human connection. The long-term care environment may offer limited opportunities for casual social interaction, and asking you about yourself may be one way of engaging in a kind of interaction they once enjoyed but now have little access to. Sharing personal information also helps the resident feel comfortable with you as a person, as someone he can like and trust. At another level, sharing information shifts control to the resident. When he asks questions, he is control of the social situation. Use your judgment about how much personal disclosure seems appropriate.

In the end, you will need to think carefully about the balance in this first session between asserting your professionalism and using a more colloquial approach to enhance the therapeutic relationship. By sharing personal information you don't want to undermine your professional role, confuse the nature of your relationship, or negate the psychological benefit of "sharing your status" with the resident.

⑤ Clarify confidentiality, fees, and scheduling

Describe confidentiality but also be clear about its limits. Tell the resident what information you will be placing in his chart, who has access to that information, who you will talk to on the treatment team, and what kind of information you will share with them. Recognize that progress notes in medical charts tend to be available to more individuals than private treatment charts. Progress notes need to be informative about the resident's status, but they need not include exhaustive detail about the content of sessions (see Chapter 3, *Clinical Considerations*).

Discuss with the resident the legal and ethical limitations of confidentiality (e.g., abuse in the case of minors or elders, potential physical harm to self or others). This requires you to be familiar with your state's regulations regarding abuse reporting requirements. In general, you probably will not share information with staff or family

members unless you have 1) obtained verbal consent from the resident, and 2) it is important for the resident's treatment that the staff or family member have the information. Some family members or staff may approach you for information about the resident, and while it may be appropriate to share some information about the resident's progress or treatment plan, you should be wary of sharing specific information that violates the spirit of the confidential psychotherapy relationship.

Know the policy of your residence about billing and share with the resident information about how appointments are paid for. In some long-term care facilities there are no separate fees that a resident pays for seeing a therapist. For qualified mental health providers, Medicare Part B pays for a portion of psychotherapy services, and many residents have a secondary policy that will cover the remainder or another portion of the bill. What is not covered by insurance will need to be billed directly to the resident. It is important that the resident is aware that he may need to contribute to the cost of treatment. In many cases family members have assumed responsibility for the resident's finances, so, with permission of the resident, you may wish to discuss financial arrangements with the responsible party. Some residents may be concerned about the expense, and some may even decline therapy because of it. In any case, for both residents who do and do not pay out of pocket for their therapy, you may want to consider how their financial investment (or lack of) in the treatment could influence motivation.

Discuss what day and time the resident is able to meet for therapy, noting that the sessions are, at least in the beginning, twice a week for 20-30 minutes. Also clarify where you will meet. If you meet in the resident's room, will his roommate be out of the room with certainty? If elsewhere, who is responsible for transporting the resident to/from therapy? Before ending the session, review the next appointment date/time. Leave with the resident a written card that states your name, phone number, the date and time of your next appointment, and where it will be or how you will meet. Make sure this is written in large enough print for the resident to see. If he has a calendar, you can offer to record the next appointment information for him. You might also leave a descriptive brochure about therapy if you have one available. Be sensitive to confidentiality in these actions too. A brochure left on a bedside table may be visible to other residents and staff.

⑥ Instill hope and positive expectations for success

Research has shown that positive expectations are associated with positive therapy outcomes. If clients are hopeful about therapy's ability to help them they are more likely to improve (Kirsch, 1990). Consequently, during this session an important goal is to communicate hope to the client. Here's an example.

Therapist: Psychotherapy is no magic cure for depression, but in my experience I've found that many people benefit from

talking with someone on a regular basis. I've worked with other older people who have had similar feelings to yours, and many of them feel better after being in therapy. I have every reason to believe that you can feel better too.

One aspect of educating the resident is creating positive expectations for improvement while acknowledging what therapy can and cannot do. Point out that he may not see improvement right away. Rather, it may take a few sessions before he begins to feel differently. Also note that the course of therapy often is not steady:

Therapist: You will probably have good days and bad days, but my hope is that the number of bad days you have will become fewer and farther apart.

⑦ Build rapport with the resident

Psychotherapy is more likely to be successful if the resident feels comfortable with you, can share his thoughts and feelings with you, can trust you to help him. Some simple, and perhaps obvious strategies to accomplish that are to be friendly, respectful, and empathic. Listen well and provide encouragement. Here are some examples of what you might say or do to help establish a positive therapeutic alliance.

- “I understand that you’ve been feeling down recently, and I want to help you get back to being your old self.”
- “I’m glad to have the chance to meet you, and I’m looking forward to working together over the next few weeks.”
- “I believe there is a good chance that together we can make things better for you.”
- “I care about how you are feeling, and I want you to feel better.”
- Use empathic body language: sit near the client, make consistent eye contact, nod and offer verbal affirmation.
- Place a gentle hand on the resident’s arm to convey warmth.
- Throughout the session ask if the resident has any questions.
- Because of cognitive impairment, you might repeat information to reinforce what you’ve said.

These are just examples. Knight's (1996) book on psychotherapy with older adults has a chapter on building rapport with clients. Naturally, good rapport depends on more than just a few well-placed phrases. Having a genuine concern for the resident and a sincere belief that you can help him is a good foundation. Conveying interest and respect are important. You need to demonstrate a concern for the resident's well-being and an active desire to know and help him.

As you've read this chapter you may have wondered how you can possibly cover all this material in one session. In some cases you can't. What we've outlined here is a comprehensive guide; what you end up doing is going to differ from resident to resident.

The difficult balance in this session, to put it simply, is how much to talk and how much to listen. You can spend a large portion of the session giving useful information to the resident. You will want to be careful, however, that you don't spend all that time giving information at the expense of receiving information, of listening to the resident and establishing a good working relationship. Residents who have significant cognitive impairment may be overwhelmed by too much information. And residents who are skeptical about psychotherapy may feel put off if you do all the talking and it's all about topics that they don't perceive as relevant to their situation. The first session is a delicate dance: part teaching, part being taught; part recruitment, part listening. Your clinical judgment is a key tool in navigating this first critical session.

FIRST SESSION CHECKLIST

GOAL	ACTION / TECHNIQUE
review reasons for referral	<input type="checkbox"/> review source of referral <input type="checkbox"/> review reason for referral, including specific symptoms
provide information about depression	<input type="checkbox"/> normalize the experience of depression in older adults <input type="checkbox"/> provide information about common symptoms of depression <input type="checkbox"/> relate physical symptoms to possible psychological origins
provide information about psychotherapy	<input type="checkbox"/> normalize psychotherapy <input type="checkbox"/> explain therapeutic relationship, its difference from other relationships <input type="checkbox"/> discuss general mechanisms of therapeutic change; why therapy works <input type="checkbox"/> acknowledge possible limitations of therapy <input type="checkbox"/> create positive expectation for success of therapy <input type="checkbox"/> emphasize collaborative nature of therapy <input type="checkbox"/> discuss structure and course of this therapy
provide information about yourself	<input type="checkbox"/> discuss credentials, experience <input type="checkbox"/> describe how you can be contacted
clarify confidentiality, fees, and scheduling	<input type="checkbox"/> discuss confidentiality and its limits <input type="checkbox"/> share information about billing <input type="checkbox"/> schedule next appointment <input type="checkbox"/> provide written reminder of next appointment <input type="checkbox"/> leave other appropriate written information
instill hope	<input type="checkbox"/> express optimism about improvement
build rapport	<input type="checkbox"/> offer empathic verbal and nonverbal support <input type="checkbox"/> listen attentively <input type="checkbox"/> be respectful

Chapter 7 ~ Restore

The development of depression is related to changes residents may experience in three realms: 1) changes associated with aging, 2) changes associated with dementia, and 3) changes associated with living in a long-term care residence. The first phase of REM treatment involves acknowledging and addressing those changes that influence the individual's sense of emotional well being.

As a group, the changes mentioned above have at least one thing in common: they all represent some form of loss (Cotrell & Schulz, 1993). Functional abilities, personal freedoms, and relationships that are taken for granted earlier in life can no longer be assumed. Examples of common changes include not being able to control one's bladder; losing the ability to engage in favorite leisure activities, such as playing bridge or bowling; and having to conform to unfamiliar routines, such as rising at 6 am or eating dinner at 5 pm. Many relationships may be lost, through death, relocation, or illness, thereby limiting opportunities to love and be loved.

Losses exert an influence in at least two ways. First, losses change everyday life. Having fewer social interactions, being confined to a particular room or floor, being treated with a lack of respect, living with continuous pain—these losses can contribute to depression. Second, when individuals reflect on their losses they may feel badly about themselves, particularly when the loss is related to their functioning. Even residents with cognitive impairment may realize that they are not the same person they used to be. Awareness that one cannot do so many things one used to do may prompt a decline in self-confidence and feelings of self-worth.

In light of the significance of losses, this first phase of treatment focuses on establishing a solid working relationship with the resident, acknowledging the resident's difficult situation, and helping to establish a coherent sense of personal identity and self-esteem.

Goals of the Restore phase

- ❶ develop a strong therapeutic relationship and instill hopefulness
- ❷ provide empathic acknowledgment of the resident's experience
- ❸ restore a positive sense of self
- ❹ continue assessment and integrate it into therapy

❶ Develop the therapeutic relationship and instill hopefulness

Naturally, the therapeutic relationship develops throughout your work with a

resident, but during these initial sessions your efforts to build and strengthen that relationship are particularly important. Demonstrate warmth, sincerity, and caring in your relationship with the resident. Listen attentively and express interest in what the resident is saying. Be consistent and punctual with your sessions to demonstrate that the time you spend together is important. In addition, you can enhance the resident's motivation for treatment by promoting feelings of hopefulness and optimism. At the end of the first few sessions you can reiterate your belief in the usefulness of therapy and the ways in which you think the process can be helpful to the resident.

🕒 Provide empathic acknowledgment of the resident's experience

Older adults face many developmental challenges that can affect mental health. Some biological, psychological, and social events or changes are natural (albeit unwelcome) aspects of aging. For instance, decreased sensory acuity is a common experience for older adults. Other challenges, however, are unexpected or "abnormal." Moving permanently to a nursing home, for example, is a relatively unusual experience for older adults in the United States. Likewise, cognitive impairment is not a normal part of growing old, although it becomes more common with advancing age.

As mentioned earlier, one thread that connects many of the experiences of older adults is that they represent some form of loss. You might begin therapy by taking a formal or informal inventory of a resident's losses. Below are more examples of the losses that older long-term care residents may experience.

- Losses associated with aging

Physical

- decreased stamina, vigor, and energy may make it difficult to pursue previously enjoyed activities
- chronic physical disability may limit activity
- chronic illness may produce fatigue, discomfort
- pain may limit activity
- decreased sensory acuity may make experiences less pleasurable
- sensory impairment may make a resident reluctant to participate in activities where his deficits might be embarrassing

Psychological

- psychological distance from children as attention focuses on their own families and careers
- disappearance of former roles that once contributed a sense of personal identity (e.g., worker, spouse, volunteer)
- realization that life is drawing to an end; Eriksonian ego identity crisis may occur as an individual struggles with integrity versus despair

- lack of control; more decisions are made by others and freedom is limited
- long-term consequences of repeated thwarting of control may lead to passivity, learned helplessness
- general psychological deprivation due to fewer opportunities for pleasurable events or experiences

Social

- smaller social network as spouse, family, and friends age and die; relocation of friends as they move or enter other long-term care residences
 - confinement; physical problems or transportation difficulties may limit possibilities for social interaction
 - geographical distance from children and other family
 - devaluation by society; general negative attitudes toward and stereotypes of older adults
- Losses associated with entering a nursing home
 - loss of home; a familiar place with one's own possessions is left behind
 - loss of freedom; choices are more limited regarding meals, daily schedule, whom one can associate with, where one can go, environmental design
 - loss of social contacts; some individuals have limited access to friends and family
 - loss of privacy; sharing a room with a roommate, communal dining, more public bathing than in a private home
 - loss of respect; ageist responses from staff
 - loss of psychological stability; previous routines and preferences may be ignored; unresolved conflicts with family from an earlier phase of life may be reactivated by the challenges of relocation; interpersonal deficits may be accentuated in the new communal living environment
 - Losses associated with dementia
 - cognitive skills; awareness and distress over cognitive deficits may compromise feelings of competency; may make a resident hesitant to put himself in situations where his deficits may be obvious to others; impaired reasoning and judgment may make it difficult for a resident to use adaptive coping strategies when faced with a problem, and therefore his reaction may be more extreme or catastrophic
 - viability of defense mechanisms; memory deterioration may "release" previous traumatic memories; old conflicts may reemerge as if they are current
 - social interaction; other residents may respond negatively when they see someone with cognitive deficits because they are reminded of their own vulnerability
 - respect; residents with dementia may be even more marginalized by staff who may think that "nothing can be done for someone with dementia"

The losses outlined above may have varying meanings or degrees of significance for different residents, so careful exploration is important. As you learn more about the resident, listen for these topics and investigate their meaning. There are some clear behavioral manifestations of grief and loss that may be apparent as the resident talks about his losses. Crying, lack of eye contact, anger, and rage may surface. Be attuned to nonverbal cues. In addition, you may find that the resident spends much time comparing his current self to his past self. Comments such as, “I used to be able to walk three miles a day, but now I can’t even make it to the bathroom,” reveal elements of the resident’s previous sense of identity, and identify a loss that may be mourned. Family members also may provide a useful perspective on how the resident has changed: “She used to be an incredible knitter, making sweaters and blankets all the time, but now she doesn’t seem to be as interested. I bring her yarn and it just sits in her room.”

Some therapists wonder how self-esteem and self-concept can be maintained when older individuals face very real and often dramatic changes in their lives. The fact is that many older adults *do* have difficulty walking as they used to, they *do* live in an unfamiliar place with unfamiliar people, and they *are* separated from their families. Physical frailties may keep mounting. Death may be closer. These are realities. In the Restore phase of treatment the goal is to acknowledge these changes, empathize with the difficulties that accompany them, and collaborate with the resident on finding meaning and satisfaction in life despite these challenging circumstances.

⑥ Restore a positive sense of self

Losses can bring about a deterioration in self-esteem and, more generally, a loss of sense of self. In brief, the self represents the collection of motivations, attitudes, and behaviors that define a person’s identity and contribute to a sense of meaning of life (McAdams, 1993). People tend to be happier and more resilient to stressors if they have an internalized sense of who they are, and a sense of themselves as being worthwhile, valued, and competent (Tobin, 1999; Vittoria, 1998).

Below are some strategies, techniques, and examples of how to bolster self-esteem and preserve continuity of the self.

- Be aware of genuine, immediate needs

Before you start a therapy session, acknowledge real needs that may demand attention before the resident can participate comfortably.

- Ask if he needs to go to the bathroom or needs to be changed with assistance from staff.
- Ask if he is comfortable in his chair.
- Ask if he is warm or cool enough.
- Ask if he needs anything to drink.

- Determine whether the resident is experiencing any pain that might interfere with his concentration; be particularly watchful for nonverbal indicators of pain.

- Provide positive feedback for involvement in therapy

Offer simple, sincere compliments about the resident or your interactions with him.

- “I appreciate your willingness to be so open about your feelings.”
- “I admire your commitment to our work together.”
- “I know sometimes you don’t feel like coming to your appointments, but I admire your trying.”

- Provide genuine empathy and listen actively

- “It sounds like this move to the nursing home has been a real challenge for you.”
- “So you get upset when your roommate ignores your agreement to turn the lights out by 10:00?”
- “If I understand you correctly, you’re angry that your daughter hasn’t been to see you in two weeks.”

Recall stories the resident has told you to instill in him a sense of being known.

- “I remember you telling me about that camping trip with your brother.”
- “That reminds me of the time you stood up to your boss.”

- Help the resident maintain continuity of self

Ask questions to learn more about the resident.

- “What are you most proud of in your life?”
- “How do you usually handle stressful situations?”
- “What do you think is your biggest problem these days?”

Encourage reminiscence to identify and reconnect the resident with his accomplishments, capabilities, and strengths.

- “Tell me about your children.”
- “What do you remember about the war years?”
- “You were a dedicated father and employee for all those years.”
- “That’s a nice photo of your family you have there. Tell me about your picture.”
- “Let’s talk about those years when you and your wife were working hard to get that business going.”

- Facilitate the resident's search for meaning in life
 - "What kinds of things do you look forward to?"
 - "How do you explain why you are still alive given all you've been through?"
 - "What kind of ideas do you have about why you are here on this earth?"
 - Discuss the value of relationships, contributions to society, altruism, and other aspects of life they find meaningful.
- Help the resident organize his/her thoughts and feelings

Paraphrase comments.

- "So, you're saying that you have a hard time getting help when you need it."
- "If I understand you correctly, you're saying that you wish you a choice about when you get your bath."
- "So, you feel sad that your son is so far away."

Summarize and reflect themes.

- "I wonder if you were angry when your family made that decision without talking to you."
- "I see that your eyes got a little teary there. Is this making you sad?"
- "You've been talking a lot about missing important people in your life."

Repeat information to reinforce its importance and to foster retention.

- "As I said, we'll meet next Tuesday at 2:30, and I'll come get you."
- "You've told me today that your roommate is driving you crazy but you don't want to switch rooms because you don't want to hurt his feelings. Next week we'll continue to talk about ways to cope with his behavior."

Use rituals to create and maintain the "set" for treatment.

- Start each session with the same opening phrase: "OK, let's start today's session."
- Use the same positions/layout in the therapy room.
- Review material from the previous session.
- Close the session with a summary.
- Reiterate that therapy will continue at the next session.

- Encourage emotional expression

Empathize with the difficulty of expressing emotions.

- “I know it’s hard to talk about these things, but sometimes it’s good to get it off your chest.”
- “It seems like you’ve been holding those feelings inside for a long time.”
- “Therapy is a place where I want you to feel comfortable sharing all your feelings.”
- “Sometimes people want to put on a good face to cover up their emotions, but this is a place where you can feel free to say exactly how you’re feeling.”

Encourage awareness of emotions.

- “Stop for a second and tell me how you are feeling right now. What is your body feeling at this moment?”
- “Pretend you are looking at yourself in a mirror. What kind of emotion do you think you would see in your face?”
- “How did you feel when your daughter told you she wouldn’t be taking you out for the holiday?”
- “I’m interested in hearing how you were feeling during that time.”

Provide opportunities for catharsis and emotional release.

- “Tell me more about how angry you’re feeling.”
- “You must have some pretty strong feelings about that.”
- “It’s OK if you want to cry.”

Provide empathic responses to the resident’s experience.

- “I can see how hard it is to talk about these things, and you’re doing a great job.”
- “That sounds like it was a difficult time for you.”
- “It’s hard to lose someone you care about.”
- “What a challenge that must have been in your life.”

- Validate and normalize loss

Acknowledge that losses are common and may continue.

- “Many older people experience similar problems with their bladder.”
- “I’ve talked with other people who have also developed difficulty walking just like you have.”
- “Yes, your eyesight is likely to get worse in the coming years.”

- “It’s hard when all your friends get old and start to die.”
- “You may actually find that it gets more and more difficult to remember people’s names.”

Recognize the resident’s difficulties and limitations.

- “It’s frustrating when you can’t remember things like you used to.”
- “It’s hard to make friends in a new place.”
- “I understand that your arthritis makes it difficult for you to get around.”

Encourage acceptance of limitations.

- “It’s hard to think about what you can’t do, but now the challenge for you is to concentrate on what you *can* do.”
- “Although it’s not like your own home, let’s work on finding ways to make this place feel like home.”
- “Even though you’d like to do it, it may be unsafe for you to walk to the bathroom without help.”

- Enhance the resident’s sense of self-worth

Praise existing abilities and competencies.

- “I’ve seen how you make the staff and residents smile with your quick sense of humor.”
- “Every time we meet you’ve done such a nice job of making yourself look good.”
- “You really go out of your way to help other residents when they need it.”
- “I see that you’ve learned to navigate that wheelchair around the floor pretty well.”
- “Despite your arthritis, you’re still able to eat, smile, and hold my hand.”
- “When you make an effort to talk to the other residents you really brighten their day.”
- “You’re doing a great job in following through with your exercise program.”
- “People must like spending time with you with that great sense of humor you have.”
- “You’re very thoughtful toward your roommate - she’s lucky to have you.”

Allow the resident to “borrow” your status as a professional.

- “I’ve let the other staff know that we’ll be meeting at this time for the next few weeks.”
- “Let’s go talk with the nurse manager after our session to discuss your concerns.”
- “I’ve asked your physician to talk with you about a physical therapy consultation.”

Convey respect for the resident.

- “Your time is important, and I want our meetings to be valuable for you.”
- Use the resident’s preferred form of address (first name, Mr., Mrs., Dr.).
- Show up for appointments on time.
- Conduct therapy sessions in a private place that minimizes interruptions.

Praise the resident’s efforts in therapy.

- “Even though it might not seem like much, you are moving in the right direction and taking important small steps.”
- “I have noticed that you are making good progress toward your treatment goals, and I want to congratulate you on the work you are putting into getting better.”

④ Continue assessment and integrate it into therapy

A final goal of the Restore phase is to continue to integrate what you learn about the resident into your therapeutic work. Throughout treatment you will pick up details about his history and personality and about how he views the world; or you may develop a more accurate estimate of his level of cognitive functioning. With that information you may decide to spend more time at the end of each session repeating and reinforcing what you have talked about. As another example, in the course of your sessions you may learn that a resident is much more energetic and alert early in the morning, and you may choose to shift your sessions from a less productive afternoon time.

Are you ready to move to the next phase of treatment?

When is the Restore phase finished? How do you know when the resident is ready for Empower? First of all, aspects of the Restore phase are never really finished. For example, you don’t stop being empathic or offering positive reinforcement when you move on to a new phase of treatment. Instead, the proportion of time you spend in session doing Restore interventions versus Empower interventions probably will shift. But how do you know when the resident is ready for Empowering? Listed below are indicators that the resident has made some progress and may be ready for the more active, agency-building interventions in the Empower phase:

- improvements in the resident’s appearance, improved hygiene, cleanliness, orderliness;
- more positive self-description and self-labeling, resident makes fewer disparaging comments about self;
- more positive cognitions and verbalizations about self, others, the future;
- fewer cognitions and verbalizations about death or wanting to die;

- fewer cognitions and verbalizations about helplessness, hopelessness, or pessimism;
- more active, problem-solving behaviors;
- better modulation of angry affect and hostile behavior;
- eating and appetite begin to improve;
- sleep is less disrupted and more restful;
- fewer somatic complaints;
- increased social engagement.

A resident may become conditioned to use the therapy hour to express mostly negative affect, so you may not get a reliable self-report of improvement early in the therapy. You may notice, however, that in session the resident is more upbeat, less self-critical, and seems to have more energy, all possible indicators of an uplifting of mood. Similarly, the staff may report that the resident is spending more time out of his room and that his appetite has improved. When you consider information from multiple sources you may get a more accurate picture of the resident's progress.

RESTORE CHECKLIST

GOAL	ACTION / TECHNIQUE
develop a strong therapeutic relationship and instill hopefulness	<input type="checkbox"/> ask questions to gather additional information about the resident <input type="checkbox"/> instill optimism about the potential success of therapy
provide empathic acknowledgment of the resident's experience	<input type="checkbox"/> assess and address losses associated with a) aging b) entering a long-term care residence c) dementia
restore positive sense of self	<input type="checkbox"/> be aware of genuine, immediate needs <input type="checkbox"/> provide positive feedback for involvement in therapy <input type="checkbox"/> provide genuine empathy and listen actively <input type="checkbox"/> help the resident maintain continuity of self <input type="checkbox"/> facilitate search for meaning <input type="checkbox"/> help the resident organize his/her thoughts and feelings <input type="checkbox"/> encourage emotional expression <input type="checkbox"/> validate and normalize loss <input type="checkbox"/> enhance the resident's sense of self-worth
continue assessment and integrate it into therapy	<input type="checkbox"/> adapt the content or process of therapy to accommodate new information about the resident

Chapter 8 ~ Empower

This second phase of treatment helps residents become active, positive agents in affecting their own well being. As the name suggests, the goal of this phase is to empower, motivate, and energize residents. Empowerment involves nurturing residents' beliefs that they are capable of creating positive change in their lives and assisting them to determine how to create that change.

One key aspect of the Empower phase is encouraging residents to see themselves as effective, powerful people who have the skills to make their lives more satisfying. Residents should begin to feel that they have control over their lives and that they can face problems and challenges with confidence and success. A firm belief in personal control is essential. Research suggests that perceptions of control are important for older adults' quality of life (Perlmutter & Eads, 1998), even when control revolves around the simplest of daily choices and routines.

A belief in control by itself, though, is not enough. The Empower phase of treatment also aims to put belief into action. Residents need to recognize that they can do something to get what they want.

Enhancing both memory and self-efficacy

Mrs. K has been troubled by her deteriorating memory. An accountant by training, she prides herself on her proficiency with figures and her independence. One element of Mrs. K's current depression is that she feels discouraged by her inability to remember simple aspects of her everyday life. For example, she needs to ask the staff repeatedly to remind her of the time for her daily respiratory appointment. She recently has had trouble recalling her room number as well. Recognizing these problems fuels her feelings of worthlessness and hopelessness.

Because Mrs. K retains many skills, her therapist recognizes that she may be able to benefit from some simple behavioral interventions. So, together they brainstorm about ways Mrs. K can better recall information that would enable her to function more independently in the nursing home. Her therapist teaches her mnemonic strategies, and Mrs. K decides to purchase a small notebook to keep in her shirt pocket. In there she records important dates and times, and she can refer to her notebook at her leisure. Her memory deficits are no longer as public, no longer as embarrassing to Mrs. K, and she feels

more confident about her ability to manage her daily life.

Mrs. K needed to recognize that there were ways in which she could exert some control over her life, that there were things she could do to regain some of her independence. With the help of her therapist she was able to reflect on what she *could* do and develop strategies for putting a plan into action.

Goals of the Empower phase

- ① enhance perceptions of personal competence and control
 - ② encourage adaptive coping skills
-

① Enhance perceptions of personal competence and control

People like to have control over their lives. Perceived control is associated with better health and well being within institutions (Rodin & Langer, 1977; Janoff-Bulman & Marshall, 1982). A lack of control, on the other hand, is associated with low self-esteem, feelings of helplessness, and poor physical health, all of which can contribute to depression in some individuals.

A woman who lives in a nursing home may not feel like she has much control over her life. The nursing home may have standard schedules that determine when she is woken up, when she gets dressed, when she eats, when she participates in activities, and when she goes to bed. Often there is little flexibility in schedules, and certainly nothing like the flexibility that people are accustomed to when they live at home. As a whole, the nursing home environment can present limited opportunities for people to make decisions for themselves.

In fact, the very nature of institutional living can reinforce dependency. Residents who are quiet, compliant, and undemanding are often more popular with the staff. They are the “good” residents who make few demands and are easy to work with. In other words, they give up control to the staff, and for this they are praised and treated nicely. Meanwhile, the residents who make requests, who let the staff know what they want, and who try to exert their free will may be viewed as troublesome, demanding, and difficult. Some staff, whether consciously or unconsciously, may avoid these residents or react negatively when the residents ask for something. A curt, angry response from the staff can be a subtle way of punishing a resident for her assertiveness.

Another consideration is that older individuals may be reluctant to “make a fuss” by asking for things. They may avoid any expression of preference or desire if it raises

the possibility of burdening others. Residents also may not want to take attention from others “who need it more than me.” These attitudes may be driven by cohort factors, by personality, by the need to perceive themselves as better off than their peers, and/or by depression. You may need to help residents understand that they have rights and deserve to be treated in a manner that is caring and respectful of their autonomy.

Some residents may have never been assertive. Asking them to take control and be assertive at this point may not be consistent with their personality and life long behavior. In this situation you need to think about what is realistic. Returning to the example at the beginning of this section, Mrs. K may not have felt comfortable approaching the staff for assistance, but she did feel good about taking personal control over her activity.

Unfortunately, even when residents express their desires the staff do not always respond. A resident with limited mobility may ask the staff to place her in a public area so she can talk to other people, but the staff may see that as a low priority. Prepare the resident for this possibility. When it happens, discuss it and use it as an opportunity to brainstorm with the resident about why she did not get the result she wanted and what she might try next. As you work to establish perceptions of control in this phase of treatment, be prepared to acknowledge the limitations of control as well.

Below are a number of strategies to enhance perceptions of competence and control in the resident’s life:

- Review past coping successes

Discuss times in the resident’s life when she has been able to exert control. Examples might come from her life before she moved to the nursing home or since she has been here. Job successes, financial accomplishments, robust social networks, and family ties are all situations that require control and self-direction. In the nursing home, success in rehabilitation or positive past experiences with psychotherapy may be helpful recollections. Residents who are depressed and demented may have trouble recalling these past examples and they may need your help to recreate those memories.

- Emphasize current strengths

Empowering the resident involves pointing out to her the ways in which she is still competent and capable. All residents appropriate for this treatment, no matter how depressed or impaired, have some preserved strengths that you can reflect on with them. Residents with physical disabilities may retain enviable social skills, a quick wit, or an ability to make other people feel better with their warmth and sense of humor. Residents with increasing cognitive impairment may have physical skills that remain intact and enable them to do much for themselves. Some residents with significant cognitive limitations possess preserved social skills. Older individuals in nursing homes may have great stature in their families by virtue of their position as patriarch or matriarch. An ex-painter with visual impairments may be able to exercise her creativity through music

or sculpting. Think carefully about what the resident can do, and highlight that as a strength.

The resident's willingness and ability to establish a working relationship with you in order to improve her condition is an often overlooked strength. Highlight that accomplishment too.

- Identify current circumstances where control is possible

Although a resident may feel she has little control over her daily life, you may be able to help the resident see that there are, in fact, situations where she can assert some autonomy. For instance, you may be able to help the resident set up a meeting with the dietician to discuss food preferences. Similarly, the resident may have more control than she thinks about where she can sit in the dining room, what time to go to bed, what activities to attend, decoration of her room, etc. Even something as simple as deciding where to place photographs around her room may be a worthwhile expression of autonomy.

For additional examples think in simple, basic terms about choices the resident makes (or could make) every day. The choices involved in everyday living may not seem like significant illustrations of independence to you, but they take on added importance in residential living. The point is to give the resident immediate, concrete ways to exert control.

The naysayer

Some people find it difficult to say anything positive about themselves or their accomplishments. Usually out of modesty but sometimes out of pessimism, individuals may not help you identify their past successes at exerting control. Individuals with depression may find it particularly difficult to say positive things about themselves. "Oh, that wasn't a big deal; anybody would have done that," might be one response to your attempts to highlight a success.

One strategy for handling naysayers is to ask how other people might have viewed the accomplishment. Another technique is to ask how they would feel if someone else had done the same thing. You might also discuss in more detail the consequences of the behavior in order to highlight a positive outcome. Finally, you also can encourage less black-and-white thinking: "Maybe you'd do things differently now. But it sounds like you did the best you could at the time."

- Discuss the resident's preferences for everyday living

Staff may know little about what is important to a resident and how she likes to conduct her everyday life. Asking a resident about her preferences can be validating because it communicates that her opinions are valued. That kind of discussion also creates an opportunity to examine discrepancies between what the resident would like and what the environment actually provides. You may find it valuable to elicit a resident's preferences regarding foods, leisure activities, family contact, privacy, availability of dentures/glasses/hearing aids, room temperature, and other environmental features.

- Encourage the resident to verbalize her concerns

A resident should know that it is appropriate and important for her to tell the staff what she needs to make her life comfortable and satisfying. In some cases a resident may be reluctant to make her needs known for fear of appearing too demanding, pushy, or bossy. In other cases a resident may not understand exactly how a nursing home works, and she may be unsure if it is appropriate to make certain requests. Or, she may understand perfectly well how the nursing home works, and her reluctance to speak up may be a reaction to an unresponsive environment. In addition, depression may dampen a resident's willingness to be assertive. Low energy, feelings of worthlessness, and a desire to withdraw may hinder the ability to speak up for oneself.

Encourage the resident to take responsibility for her circumstances. This may involve traditional cognitive therapy activities such as challenging the resident to examine her beliefs, gather evidence, and evaluate the validity of her beliefs. Challenge her by asking, "What do you think would happen if you did ask?" Also, don't underestimate the power that you can have by using your professional status to give the resident "permission" to make requests.

- Acknowledge the limits of control

An unfortunate reality is that for many residents there are limitations on what can be controlled. Being in a long-term care residence involves a certain loss of control because of its structure. Long-term care facilities must serve a community of individuals, and residents need to be realistic about which of their personal preferences can be met. For example, just because a resident wants to smoke in her room doesn't mean that the residence can accommodate her request.

Before discussing options for control with the resident, it is important for you to be aware of institutional limitations. You will need to be aware of the constraints of the organization before offering possibilities to the resident. For instance, a change in the resident's bathing time may seem like a reasonable request to you, but without proper staffing it may not be possible.

Perhaps the best perspective to take on this issue is to recognize that your goal should not be to institute a wholesale change in how the residence operates, but rather

to reach some compromise between what the resident wants and what the residence can provide. A resident may not be able to pick the exact time for her bath, but she may be able to choose whether to have one in the morning or the evening. You can help the resident prioritize her needs and preferences.

② Encourage adaptive coping skills

When a resident feels competent and in control, she is prepared to make changes in her life. But just because she is ready doesn't mean she knows the best way to make changes. For example, demanding to speak to the nursing home administrator to have the temperature in her room raised may not be the most effective way to get the job done.

There are a number of coping skills that can help a resident make positive, adaptive changes that have a good chance for success. At this phase in the therapy the goal is to develop strategies and prepare the resident for change. You can help the resident to be more aware of her emotions and more motivated to act. You also can help the resident generate ideas, develop plans, and brainstorm on her own. This is preparatory work that will lead to action that is characteristic of the subsequent Mobilize phase of treatment. Below are some strategies that may be helpful.

- Help the resident identify and label her emotions.

For some residents psychotherapy may be a new process and they may not be used to reflecting on their own mental life. You can assist them in paying attention to their emotions and learning to identify how they are feeling.

- Help the resident express anger in productive ways.

Anger may feel empowering to a resident because it is an activating emotion. Keep in mind, however, that anger is most productive when it can be galvanized and focused toward a positive goal. After recognizing this emotion, residents may need assistance in channeling that energy into potential solutions.

- Challenge resistance.

When residents are reluctant to engage in therapy or hesitant to participate in the therapeutic activities you suggest you might consider whether they are demonstrating resistance. What are the benefits they may gain from staying depressed and unhappy? Is there a pattern of premorbid passivity that is influencing their ability to make progress? Investigate resistance and address it when the resident chooses to avoid a problem. Be mindful of how the resident responds to confrontation and modify your approach so as not to elicit further withdrawal from the resident.

- Use reminiscence as a coping tool.

Reminiscing about pleasant and meaningful past experiences can be an effective tool to increase positive feelings. This can be done during the therapy session or the resident can be encouraged to reflect on such experiences between sessions as a strategy to combat feelings of sadness or low self worth.

The challenge of apathy

Getting the resident involved in therapy can be challenging. The resident may feel unmotivated, apathetic, and hopeless. “Why should I bother talking about this when it’s not going to make any difference?” is a common refrain. The irony of clinical depression is that it leaves residents feeling apathetic just when their improvement demands action. Therapists need patience and gentle persistence to engage the resident.

- Help the resident establish meaningful relationships with people in the residence. Ask the resident who her important friends are, whom she might like to know better, and what social activities she might like to pursue. In some cases roommates can be valuable social contacts. Other peers throughout the residence may be potential confidantes. Some residents may get personal satisfaction from taking a caring role and helping others in the nursing home. For instance, a wife who previously cared for an ailing husband might find fulfillment in being helpful to her roommate. Or a resident may gain some satisfaction from being responsible for accompanying another resident to a meal.

Keep in mind that some residents may be unwilling to affiliate with people who are different from themselves, whether functionally, ethnically, culturally, economically, or in terms of age. You can challenge these self-imposed social boundaries. Residents also may be hesitant to interact with others who are more ill than they are, concerned about witnessing a decline that may one day be their own. Certainly, there are risks to reaching out to others, and it is important to talk about those risks with the resident.

- Help the resident maintain relationships with people outside the institution. Phone calls, letters, and e-mail are ways to maintain important social contacts outside the nursing home. Generate a list of people the resident would like to stay in touch with (not just family, but friends and colleagues too). Create a

rough schedule of how often the resident would like to communicate with people on her list. Volunteers may be enlisted to help the resident write if she is not able to herself as a result of visual or motor difficulties. You also can facilitate visits by clergy and peers in community organizations who may not be aware that the resident would like to stay in touch.

- Enlist the staff. Consider which staff members should be included in pursuing changes the resident would like to make. Staff can provide important input and may be instrumental in proposing solutions. Including staff members in the process sends the message to residents that they, and their concerns, are important—particularly if those staff involved are perceived as having some power or authority (e.g., “I must be pretty important if the nurse manager is willing to come in and listen to this.”). Involving the staff directly this way also may increase the likelihood that they will follow through with solutions. We discuss working with staff in greater detail in Chapter 3, *Clinical Considerations*, Chapter 4, *The Importance of a Systems Perspective*, and Chapter 9, *Mobilize*.
- Enlist the family. With the resident’s permission, family members who live nearby and who visit can play an active role in treatment interventions. They can help the resident stay active (e.g., taking her to activities or out on brief trips). They can offer some instrumental support (e.g., opening and reading letters, supplying reading material, or favorite snacks). And of course they can offer emotional support. We discuss working with families in greater detail in Chapter 3, *Clinical Considerations*, Chapter 4, *The Importance of a Systems Perspective*, and Chapter 9, *Mobilize*.
- Brainstorm about pleasurable activities. One powerful approach to the treatment of depression that is emphasized in behavioral treatments is to increase pleasurable events in a resident’s life (Teri, 1994; Teri & Gallagher-Thompson, 1991; Teri, Logsdon, Uomoto, & McCurry, 1997). You can discuss with the resident the kinds of activities that might bring more joy and pleasure to her life. Emphasize that the resident has choices about how her time is spent (keeping in the mind the realistic boundaries of the residence and its resources). Encourage her to generate a list of activities she would enjoy. The Pleasant Events Schedule-Alzheimer’s Disease (Logsdon & Teri, 1997) is a valuable tool. For residents with more significant cognitive impairment or lack of motivation, you may need to generate an initial list of possibilities on your own and discuss preferences with the resident. You could post a list of pleasurable events in the resident’s room or even create a chart or checklist that the resident can mark when she has participated in these events. You might have conversations with personnel in the Activities Department to coordinate the resident’s wishes with planned activities.

- Teach the resident relaxation strategies. Basic stress reduction strategies may be new to residents but helpful in managing distress. Deep breathing, progressive muscle relaxation, and guided imagery may enhance well being. You might record an instructional audiotape for use between sessions.

Choosing the best level of intervention

To promote adaptive coping you need to consider which interventions are most likely to be beneficial for the resident. Enabling the resident to experience early success at exerting control can give the therapy momentum to tackle more difficult problems down the line.

Therefore, you may choose an intervention first that is “close” to the resident, something that is part of her daily life and has an immediate and clear impact for her. For instance, an initial discussion might focus on a resident’s desire to be able to choose what she wears in the morning. This is a circumscribed (but important) issue for many residents that represents a clear example of personal control. It is also an intervention that is relatively easy to implement in most facilities. With this initial success, the resident may feel more motivated and optimistic in addressing further changes.

- Consider social skills training. If a goal of therapy is to increase social involvement, some residents might benefit from basic training in social skills. Of course, what you can do in this arena will be determined by the resident’s level of cognitive impairment. For more intact residents, discussions about taking the perspective of others and role-playing exercises can be useful. For more impaired residents, basic feedback about a resident’s interpersonal style, repetition of this information, reinforcement of positive social behaviors, and extinction of negative social behaviors are good places to start.
- Use solution- or problem-focused strategies. Step-by-step problem solving strategies provide structure for residents who may have difficulty organizing their thoughts. It may be helpful to work with a resident through a complete problem solving exercise: identify the problem, generate alternatives, weigh those alternatives, establish a plan, evaluate results, etc. For a resident with cognitive impairment it may be helpful to write out a list of problem solving steps. Help the resident practice the process of problem solving you have developed together so she is better prepared to use this strategy on her own.

- Help residents find ways to adapt their environment. Mrs. C may have difficulty using the bathroom on her own because she is confused by the task. Yet, she is embarrassed to mention to anyone that she has problems. You might facilitate a conversation between Mrs. C and her OT so that they can construct a list of toileting steps to help cue her. That list could be mounted in her bathroom to increase her independence. In the end, a successful resident–environment match involves a balance between modifying the environment and modifying the resident’s expectations about what she can realistically do.
- Encourage meaningful activity. Replace nonproductive activities (e.g., unnecessary napping, excessive television watching) with activities that reinforce a sense of accomplishment and purpose. Socializing with other residents or engaging in simple games may be beneficial. Some facilities have programs that actively engage residents in tasks such as cooking or light housework. Exercise programs are other good options. A resident who spends her time hoarding papers might be redirected to participate in a task like folding bibs or sorting beads. Religious activities and groups can be used to reinforce previous roles and to reestablish a sense of meaningfulness. Naturally it is important to have a conversation with the resident about what makes life meaningful for her.
- Encourage flexible thinking. Residents with depression and dementia may demonstrate rigid, inflexible, or dichotomous thinking. A more adaptive cognitive style includes thinking that is balanced, fluid, and responsive to change. You can challenge the resident’s cognitive distortions about the self, about the world, and about the future. And you can encourage the resident to be more open-minded about the ambiguities and uncertainties of old age and of life in a residence. Obviously, this kind of intervention depends on a certain level of intact cognition and may not be useful for someone with marked impairment.

Are you ready to move to the next phase of treatment?

When is the Empower phase finished? Below are indicators that the resident has made some progress and may be ready for Mobilize interventions:

- initial symptoms have improved, with some lifting of depression;
- coping skills have improved, and the resident seems to possess the tools necessary to generate her own solutions to new problems;
- the resident and you have established clear, quantifiable goals about what she would like to accomplish in the Mobilize phase;
- the resident’s confidence has improved, and she talks openly and with some energy, about being ready to make changes;
- the resident possesses significant cognitive impairment that makes progress in this phase less likely and argues for greater focus on Mobilize interventions.

Many Empower interventions require intact memory, judgment, and planning. Consequently, with more impaired residents you may move more quickly to Mobilize interventions. The focus of treatment may shift to using the care environment to put supports into place for the resident.

What to do when therapy just isn't working

Despite your best efforts a resident may not make progress. Depression may be severe, or the resident may demonstrate a profound inability to initiate action and participation. Though this may feel discouraging,, there are a few options to consider.

- Temporarily increase the frequency of your sessions. The additional intensity of therapy may be enough to “jump start” your work. For instance, you might meet with a resident on Tuesday and Friday mornings for 20 minutes and then again in the afternoons for 20 more, or see her three days a week instead of two.
- Ask the resident why she thinks she is not making progress. Careful questioning may reveal an expectation of failure or secondary gain that the resident is reluctant to relinquish.
- Evaluate your working relationship with the resident. Sometimes a therapist and client simply do not connect. A frank but tactful conversation with the resident may reveal interpersonal reasons for her lack of engagement. Some of these reasons might be able to be addressed in therapy. (Indeed, some theoretical perspectives would suggest that transference and countertransference issues are necessary and fertile areas for exploration.)
- Discuss with the resident’s psychiatrist or medical care provider the possibility of adjusting (or starting) antidepressant medication. In cases of severe depression a course of ECT may be warranted.
- Consider another treatment approach. Some residents might respond more favorably to another more theoretically narrow approach (e.g., behavior therapy) or alternative treatment modality (e.g., group therapy).
- Consider termination. Psychotherapy is not right for every person. A certain degree of confidence and engagement in the process is required, and some residents simply might not be good candidates for psychotherapy.

EMPOWER CHECKLIST

GOAL

enhance perceptions
of personal
competence and
control

ACTION / TECHNIQUE

- review past coping successes
 - emphasize current strengths
 - identify current circumstances where control is possible
 - discuss the resident's preferences for everyday living
 - encourage the resident to verbalize his/her concerns
 - acknowledge the limits of control
-

encourage adaptive
coping skills

- help the resident identify and label emotions
 - help the resident express anger in productive ways
 - challenge resistance
 - use reminiscence as a coping tool
 - help the resident establish meaningful relationships with people in the institution
 - help the resident maintain relationships with people outside the institution
 - enlist the staff
 - enlist the family
 - brainstorm about pleasurable activities
 - teach the resident relaxation strategies
 - consider social skills training
 - use solution- or problem-focused strategies
 - help residents find ways to adapt their environment
 - encourage meaningful activity
 - encourage flexible thinking
-

Chapter 9 ~ Mobilize

The strategies utilized in the Restore and Empower phases may become less effective or impossible to implement over the course of your therapy if a resident's already compromised cognitive functioning continues to diminish. REM treatment anticipates the progressive nature of dementia. In the third and final phase of treatment, Mobilize, your role is to “scaffold” supports to compensate for the resident's impaired functioning in cognition and initiation. There are two goals in this phase: to activate the resident, and to activate the environment around the resident.

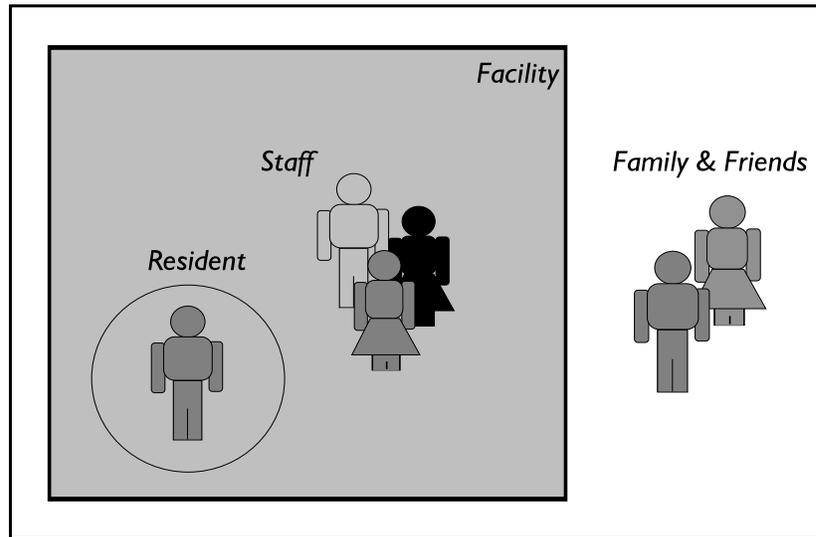
Activating the resident means helping him make the changes that you have been talking about during the Empower phase. A long-term care resident who is cognitively impaired may need assistance to make and sustain the beneficial changes that have been targeted in therapy. For example, he may lack the memory skills to initiate a desired change in routine, or mobility problems may interfere with his ability to attend an activity in another part of the residence. By the conclusion of treatment you can develop formal and informal mechanisms whereby other people around the resident can help him achieve and maintain his treatment goals. Mobilize interventions are intended to continue beyond the end of your active involvement with the resident.

Because you may find yourself working with staff and family in this phase, it may be necessary to expand how you think about the boundaries of psychotherapy, particularly if you have not worked in an institutional setting before. Unlike traditional dyadic therapies, REM focuses on more than just you and the resident. The environment in which the resident lives and the people with whom the resident interacts are important elements in the resident's mental health. It is this “system” around the resident that becomes the object of intervention.

Defining the “system”

Before moving on to the goals of this phase in more detail, we need to clarify what we mean by the “system” surrounding the resident (see Figure 3). First, there is the human environment comprised of the nursing home staff, which includes direct care staff (CNAs, RNs, therapists, physicians, psychologists, social workers), and everyone else who works in the residence (dietary staff, maintenance, environmental management, administration). Next, there is the residence environment including its structural aspects (e.g., lighting, decorations, noise level), as well as more abstract attributes (e.g., daily schedule, staff training policies, institutional philosophy). A final aspect of the system are the residents' family members and friends. Family members interact with the residents and staff and can play a powerful role in the residents' adjustment and well being. For a thorough discussion of the care system, see Chapter 4, *The Importance of a Systems Perspective*.

Figure 3. Components of the care system.



Every facet of the nursing home system can have an impact on a resident's emotional life. The direct care staff affect the resident through the attitudes, beliefs, and feelings they communicate to the resident while providing daily care. For instance, a nursing assistant who knows little about depression may chide a resident who is not motivated to get out of bed, thinking he is just being lazy. As another example, residents are more aware of staff dynamics than staff might expect. When two CNAs do not get along, a resident may be aware of the tension even if the aides think they keep their feelings well hidden. Conflict and tension among the staff can be sensed in the nursing home environment and add to how residents feel about the place where they live and possibly about themselves.

Institutional policies and programs also are part of the system and as such have an influence on the residents. A policy that prohibits residents from hanging personal items on their walls or from bringing in their own furniture may affect how comfortable and welcome the residents feel.

Finally, family members can have a profound impact on residents. A daughter who resents coming to see her father may not add anything positive to her father's quality of life and in fact may compound his distress if she complains throughout his visits. When expectations differ between residents and family members about the frequency and timing of visits, trips outside the residence, and other issues, tensions can escalate and the mental health of residents can suffer. Yet given the deep emotional bonds and long shared history typical of families, family members also have the potential to ease the transition to long-term care, provide emotional support to the resident, and help the resident navigate the long-term care system so that he obtains the best possible care.

Goals of this phase

- ❶ activate the resident
 - ❷ activate the resident's environment
-

❶ Activate the resident

In this phase of treatment you can help the resident initiate and follow through on plans that were made in the Empower phase. Now the resident is doing what he previously was learning or imagining.

As an example, perhaps in the Empower phase Mr. M talked about wanting to have more control over his bath routine. He has identified a preference to have a shower instead of a bath, and to receive it before bedtime, as this is a life long practice that relaxes him. He is frustrated with the temperature in the bathing room and with being handled roughly during the process. Mr. M has been reluctant to bring up his concerns with the staff because he doesn't want to be perceived as demanding or cranky. You and the resident have talked about how he might bring up the topic with the aide who bathes him. You have role played the conversation, talking about useful ways he can express his concerns and ask for changes. Mr. M feels ready to have this conversation with the aide, and now, in the Mobilize phase, you facilitate the conversation between the two. You motivate the resident and prepare him for the conversation; you talk with the aide alone to prepare her for the conversation; then you bring the two of them together to work on the problem.

Another important activity in this phase of treatment is preparing the resident for the possibility of relapse. One way to accomplish this is to provide education about the signs of depression. You may have done this at the beginning of therapy as well, but it is worthwhile to repeat the information. In some cases a resident will be able to monitor himself in the future so he can detect a reemergence of depression. Perhaps he spends more time in bed, sleeping more than usual, when he is depressed. Perhaps he spends less time interacting with other people and retreats to his room. The resident can learn to pay attention to these behavioral changes and identify them as mood related. You might consider putting together a depression information sheet, which could be a collaborative effort between you and the resident. The resident also can be prepared to know what to do should depression begin to recur. Get out of bed, go to social activities, spend time talking to people. The goals that you developed during this course of treatment might be relevant in future episodes of depression. Here again, leaving the resident with a written list of actions may be helpful.

As another example, in your work with Mr. D you may have learned that he tends to be less interested in following the news when he gets depressed. He may leave his newspaper unread and make little effort to listen to the radio. If you and Mr. D identify those behaviors as reliable indicators of worsening mood, he may be able to use

them as signals to himself that he needs to seek out some assistance. Similarly, getting the staff involved is helpful because they are another important set of eyes in observing the resident. Staff can be informed that Mr. D's "news" signals are useful indicators that further exploration of his mood might be warranted.

Naturally, with a resident who has significant cognitive impairment it may not be realistic to expect him to be able to monitor his own mood and behavior. Consequently, your relapse prevention efforts may focus more on staff and their ability to monitor residents for signs of change in mood.

② Activate the resident's environment

Before intervening with the system, it is helpful to have some sense of what that system looks like, who is in it, how they get along, and what the explicit and implicit institutional "rules" are. Again, see *The Importance of a Systems Perspective* for additional information.

There are many levels of the environment at which you might intervene. The following section lists areas to consider. Not every area is appropriate for every resident, but this list may give you some ideas about where to focus your efforts and how to get other people involved.

● Staff

Many staff members influence the lives of long-term care residents through their direct contact with the resident. Others have an influence indirectly through the role they play in creating the long-term care environment. Here is a list of some of the staff members to consider when thinking about the care system and who you might enlist to support the resident.

Direct contacts

- CNAs
- nurses
- nurse managers
- social workers
- physical therapists
- occupational therapists
- speech therapists
- recreation therapists
- volunteers
- clergy
- physicians

Indirect contacts

- ombudsmen
- business office staff
- LTC administrator
- CEO
- Board of Directors
- regional office

Community resources

- public libraries
- intergenerational programs
- adult educational programs
- religious organizations
- fraternal organizations
- volunteer visitation programs

Direct contacts

- psychologists
- psychiatrists
- dieticians
- laundry staff
- environmental staff
- maintenance staff
- transportation staff
- gift shop personnel
- hairdressers

Most often your interventions will focus on direct care staff because they have the most contact with the residents. There are a wide variety of interventions that focus on direct care staff. Below are some examples.

- Provide education, training, or in-services
 - Provide information about dementia, such as patterns of cognitive impairment and their effect on daily functioning, how the environment can influence behavior, behavior management principles, how to communicate effectively with residents and their family members, dealing with psychotic symptoms, dealing with sexual inappropriateness, and recognizing how dementia and personality interact.
 - Provide information about depression, such as common symptoms, natural history and progression, and goals of treatment.
 - The format for education sessions might be one-on-one, one-with-many, large classes, staff meetings, therapist-with-staff-and-patient.
 - Help staff manage their stress via empathic listening or informal education about relaxation techniques, or formal education regarding stress management, emotional intelligence, etc.
- Have informal conversations with direct care staff
 - Gather information about the resident's functioning.
 - Communicate resident preferences to staff.
 - Advise staff on how firmly to encourage residents to participate in self-care and leisure activities.
- Acknowledge staff stress
 - Recognize the heavy physical and emotional responsibilities that are part of staff duties.

- Recognize stresses outside of work that can compound work stress.
 - Acknowledge the difficulty of working with residents who may take staff attention for granted, may not seem to appreciate what is done for them, or may not have the cognitive or motivational resources to express gratitude.
 - Acknowledge that some residents may express prejudice toward staff, particularly as dementia progresses and they become more disinhibited.
 - Identify the risks of growing emotionally close to an older individual who may become sick or die.
- Communicate with relevant staff when you see a need for consults for Physical Therapy, Occupational Therapy, Audiology, Dietary, Ophthalmology and other specialty services.
- Collaborate with the medical staff
 - Through progress notes and conversations, relay what you've observed in the resident and your treatment strategy (keeping in mind confidentiality).
 - Make an effort to attend treatment team meetings.
- Respond when residents are mistreated
 - Be aware of policies (institutional or legislative) that mandate reporting.
 - Encourage residents to pursue complaints with facility representatives.
 - Forward concerns, suggestions, and complaints to appropriate administrative personnel.
- Facilitate communication between family members and staff
 - Arrange meetings between direct care staff and family members so they can share perspectives on the resident.
 - Facilitate understanding between staff and family members of each of their perspectives.
 - Clarify expectations on both sides about what the resident needs and who will provide it.
- Advocate for environmental changes
 - Gain permission (if required) to rearrange furniture or hang pictures.
 - Pursue opportunities for smoking and drinking for interested residents.
 - Pursue opportunities for sexual activity for interested residents.
 - Encourage socialization by making more chairs available in common areas.
 - Facilitate room changes when appropriate.

- Family members
 - Family who are geographically near
 - Discuss with family members how they can help the resident.
 - Provide education to the family about depression and dementia.
 - Discuss how to make family visits most beneficial to residents; this may include suggestions about the optimal frequency/duration/timing of visits, activities to engage in during visits, and what the family can reasonably expect in terms of the resident's cognitive functioning.
 - Encourage family members to advocate for the resident's interests with the staff.
 - Encourage family members to monitor staff compliance with therapeutic interventions (e.g., make sure staff are following through on efforts to bring the resident to activities).
 - Family who are geographically far
 - Provide education to the family about depression and dementia.
 - Encourage phone calls or letters that will benefit the resident.
 - Family who are emotionally near
 - Enlist the family's influence on the resident to promote positive mood and behaviors (e.g., they can give praise for accomplishments, or offer extra support in difficult times if they are aware of triggers for increased emotional distress). Be sure the resident gives permission for you to talk to the family about his treatment.
 - Accommodate the resident's desires to spend time outside of the residence with the family if possible (e.g., to go out to lunch at a nearby restaurant, visit daughter's home to attend grandchild's birthday party).
 - Family who are emotionally far
 - There may be opportunities to improve relationships that have not been satisfying by facilitating conversations between residents and family members.
 - Other responsible parties (guardian, power of attorney)
 - Facilitate conversations about the resident's preferences in many areas of everyday living (e.g., how much spending money per week, desire for private room or move to another section of the nursing home, etc.).

- Consider whether it is appropriate to reevaluate documents about treatment preferences that were put together some time ago.
- Peers and friends
 - Roommates and dining companions
 - Help to resolve disputes between roommates.
 - Encourage roommates to know one another at a more personal level.
 - Encourage the resident to support his peers as a way of engaging in roles that enhance self-esteem (i.e., giving advice, sharing wisdom).
 - Paid companions and volunteers
 - Educate about how best to support a depressed individual with dementia.
 - Provide information about helpful activities and conversation topics.
 - With the resident's permission, integrate them into relapse prevention efforts.
 - Friends outside the nursing home
 - Facilitate visits or phone calls.
 - Provide education about depression and dementia.
 - Peer clubs & organizations
 - Facilitate continued contact with fraternal or community organizations through visits, phone calls, mailings of newsletters etc.
 - Clergy
 - Facilitate visits for support and spiritual guidance.

How far “beyond” the resident do you focus your interventions?

Some Mobilize interventions focus directly on the resident and his daily life. For instance, helping a resident establish more control over the timing of his bath is a direct intervention, one that is proximal to the resident in that it has an impact on his personal, daily life. Other interventions are less direct, although they still have an eventual impact on the resident. Conducting a staff training session on depression is an indirect, more distal intervention. The training session is meant for the staff, but what they learn might influence how they treat a resident. Although there are no universal rules on the level at

which you should gear your interventions (how proximal or how distal), there are a few things to consider.

- The resident's level of cognitive impairment

Residents who are cognitively intact may benefit from interventions that involve them directly, while residents who are more impaired might benefit more from interventions that focus on the staff or environment. For instance, a resident with intact cognitive skills might benefit from social skills training. By contrast, that kind of training may not be helpful for a resident with significant memory impairment. Quality of life for a resident with memory impairment might be more significantly improved by working with an occupational therapist to establish an exercise routine for the resident.

- The "health" of the organization

In long-term care facilities where the full range of staff (from the direct care staff through the administrators) have developed an open, flexible, responsive working environment, your interventions might be successful at any level. In a well-functioning organization you may be able to consider fairly expansive interventions. For instance, management might be willing to have you conduct a staff training session on behavior problems in dementia. That kind of program is most possible in a residence where the administration supports education and where the direct care staff are enthusiastic about it.

In dysfunctional organizations, on the other hand, it might be more helpful to keep your interventions focused more directly on the resident. It won't do any good to construct interventions that are likely to fail because the organization will not support them. For example, if you offer an education program to the staff but administration requires that staff attend on their own time you are likely to face an empty room. In a residence that is less supportive you might instead focus on developing a plan to have the resident transported to activities on a regular basis or arrange for library services to visit the resident regularly. These circumscribed interventions benefit the resident, and they do not depend on a perfectly functioning system.

- Reimbursement concerns

Contemporary trends require clinicians to be mindful of the economics of what they do. How far "out" can you go and still bill for your work as a psychotherapist? Can you bill for sessions that include the family? Can you bill for time spent reviewing records, training staff, or planning an intervention that involves the staff? Regulations vary from state to state, and policies vary from residence to residence. Much depends, of course, on your role in the organization and how you are paid. You will need to be aware of how different activities are viewed in your residence. Some of your activities might not be reimbursable, even though you engage in them for the benefit of the

resident. Other activities might be framed as consultative functions that may be paid for by the facility itself (when willing).

Motivating staff to work with you

A critical element in developing successful systemic interventions is having a good relationship with the staff. We cannot emphasize enough the importance of these relationships. Establishing a good relationship is, in part, a matter of time. The more time you spend with the staff the more opportunity you have to get to know each other. Other basic suggestions include making it a point to know their names, their jobs, and to understand their stresses. Make yourself known to them as well; describe your role to the staff and tell them who you report to, what you have to offer, and how it will benefit them.

As stated before, on occasion it may be appropriate to provide education that will help the staff become more informed professionals. Ideally, this will have a ripple effect and influence the way the staff work with residents. Education programs might focus on understanding symptoms of dementia, depression, delirium, and delusions; increasing interpersonal warmth, empathy, and understanding; eliciting personal information from the resident and getting to know him as a person; or detecting the emotional underpinnings of behavior problems.

Once you have initiated a staff intervention, it is worthwhile to verify that your intervention is actually being carried out. You may choose to set up a recording procedure whereby staff can mark when they have performed the intervention. For instance, if one goal is to provide the resident with more opportunities to spend time outdoors, you could set up a chart where a nursing assistant could record the day and times that the resident was taken out, along with the resident's behavior or mood (you could provide a simple rating scale). Over time you could summarize information for the certified nursing assistant to reinforce the positive impact he or she is having on the resident. Recording procedures are most successful when they are kept simple and can be incorporated easily into the staff member's usual job responsibilities. In some situations, such as when interventions have been incorporated into the resident's care plan, written documentation may be required. This may increase adherence to the plan. In any case, frequent feedback to staff can improve the chance of success.

A less formal way of keeping track of your interventions is simply talking with the resident and staff member. Having a follow-up conversation with both the resident and staff member provides an opportunity to review the intervention, assess its success, and make modifications.

Sometimes you may find that staff do not embrace your suggestions wholeheartedly, or they may have difficulty implementing your plans in a way that is productive for the resident. Here is an example.

You and your client have decided it would be helpful if he could take a walk every afternoon. You've discussed this as a strategy that would promote a sense of confidence and independence. The CNA who is responsible for the resident during the afternoons is an essential person in this plan because she will be the one who will walk with the resident. How can you enlist the support of the nursing assistant?

- Get administrative support (e.g., from the nurse manager) for the intervention before you approach the direct care staff person.
- Build a relationship with the direct care staff member before you approach her with the plan. Make sure you have introduced yourself to her, describing your role. Having some informal conversations with the staff member and establishing a friendly connection is important groundwork.
- Collaborate with the staff member in developing the plan. Staff can provide valuable input based on their knowledge of the resident. They also may be more likely to implement a plan when they have had some input in designing it.
- Have the staff member join you and the resident for a conversation about taking a daily walk. This gives the resident a chance to explain his reasons for wanting to walk.
- Discuss what the plan is supposed to accomplish and why it is important. In this example, there are clear physical benefits to having the resident maintain some mobility. It is also appropriate, however, to talk with the staff about the emotional importance of being able to walk every day, what it means to the resident in terms of being a whole, independent person. Of course, be sensitive to issues of confidentiality in these kinds of conversations.
- Model the plan a couple of times by showing the staff member what you have in mind.
- Ask the staff member to describe the plan to you after you have described it to her. This ensures that she understands the plan as you do. Approach

this gently, by saying something such as, “I want to make sure I haven’t left anything out. Can you tell me your understanding of what we are doing and how you think this plan will be helpful for the resident? How often will you and the resident be walking together?”.

- Periodically check in with the staff member about how the intervention is going. Is it having the desired effect? Are there modifications that would improve it? Provide positive feedback to the staff member for her participation in the intervention. Review any progress you have seen in the resident to reinforce the benefit of the work the staff member is doing with the resident. At times it is appropriate to inform staff supervisors of successful intervention plans so that the staff efforts can be acknowledged and supported.

These are just some of the types of interventions that could be utilized during the Mobilize phase of treatment. There are many possible avenues of intervention, and the decision of where to focus will depend on the unique circumstances of the individual and his environment. Setting the plan in motion and developing a system to facilitate the ongoing maintenance of the plan are key components of this phase.

MOBILIZE CHECKLIST

GOAL

activate the resident

ACTION / TECHNIQUE

- assist the resident in developing plans to improve his circumstances
 - facilitate the resident's participation in strategies you have identified
 - educate the resident regarding relapse prevention
-

activate the resident's environment

- assess availability of supports and resources within the resident's environment; decide which are feasible to engage in interventions
 - train staff/companions/family members to recognize symptoms of depression and how to offer support to the resident
 - train staff/companions/family members to follow through on interventions and promote specific goals of therapy
 - provide support to staff/companions/family members regarding their care of the resident
 - monitor the residents' response to interventions and success in having their needs met by the system
 - restructure or modify the environment (when possible) to support cognitive functioning and reduce depression
-

Chapter 10 ~ Termination

Termination can be a challenging milestone for both resident and therapist. For an older individual who has already experienced multiple losses in her life, the therapist's departure may represent yet another loss with which to cope. On the other hand, some residents may view termination positively, as a sign that something important has been accomplished, that a goal has been successfully attained. Termination also represents an opportunity to say a "good goodbye"—to end well, perhaps in a way that is different than other endings the resident has experienced.

A resident may tell you directly how she feels about the end of therapy: "I'm going to miss you," or "I'm not sure I'll be O.K. without you to talk to." Other residents will be less direct. As the end of therapy approaches a resident's symptoms might worsen as a way to prolong your visits. Or she may deny any feelings about termination in order to ward off a sense of vulnerability or sadness. You'll need to listen carefully to the way a resident frames her comments about termination. Important transference issues about loss, abandonment, and rejection can be activated during the termination process.

Of course therapists have feelings about termination just as residents do, and it is important to take stock of those feelings and be aware of how they might influence your behavior. Countertransference issues about loss, death, and professional efficacy can emerge. You may grow fond of the residents you work with and may feel sad about your departure. Some therapists may feel distressed about "abandoning" an older individual. Others may wonder if their efforts will have any lasting benefit. Because older residents often face problems with no real end (e.g., chronic physical illness, deteriorating cognitive status), therapists may question the long-term usefulness of what they have provided. As Knight (1996) suggests, therapists must adopt a realistic perception of the contribution they can make to an older adult's life. At the same time, the conclusion of a successful therapy provides an opportunity to reflect on what you have accomplished.

Although termination occurs at the end of therapy, it is something you can discuss with residents at the beginning of and throughout your work together. When residents are prepared for the end of therapy, the transition to being on their own will be easier. You might think about termination as consisting of three elements: 1) things you do before the last session, 2) things you do during the last session, and 3) things you do after the last session. This section of the manual discusses each element. But first, we'll talk briefly about how you know when the resident is ready for termination.

How do you know the resident is ready for termination?

Although we suggest that REM therapy will last approximately 16 sessions, that is not a definitive number. It's a number that reflects clinical judgment about the length of therapy that appears to be sufficient for most residents (and it's a number we chose to help structure an empirical investigation of the therapy). In reality, some residents will need more than 16 sessions, and other residents will need fewer. At times, it may be valuable to hold a series of less frequent sessions beyond the 16 to taper the resident off of the therapy. Likewise, one or two "booster sessions" a month or two after you have terminated may help maintain therapeutic gains. The length of therapy depends on a number of factors including the severity of depression, the severity of cognitive impairment, the breadth and depth of the goals you are trying to address, the resident's ability to persevere with therapy, and cooperation from the treatment residence and reimbursement sources. Therefore, it is difficult to say definitively when termination is appropriate.

One indication that it is appropriate to draw therapy to a close is that the resident has accomplished her treatment goals. If you follow a treatment plan with measurable goals you can monitor your progress easily. When a resident has met the goals, therapy can be concluded. For example, termination may be appropriate when the depressive symptoms that brought a resident into therapy in the first place have improved—better mood, more energy, improved appetite and sleep, rejuvenated self-esteem. More subtle indicators that a resident is ready for termination also arise during therapy sessions. For example, the resident may seem to have less to talk about or fewer concerns when she meets with you. These may be indications that the resident feels ready to end your sessions.

What to do before the last session

Preparation for termination begins at the very first session as you describe the limited duration of treatment. Make it clear that your relationship with the resident has a specific purpose and is time limited. Talking about the limited duration of therapy prepares the resident for its end and also frames the therapeutic relationship as one that is different from other professional and personal relationships. This is not a friendship that will last and last but instead is a professional relationship in which you and the resident will work toward goals until the resident experiences some improvement. Although the resident may continue to see you around the residence after termination, your relationship will change to one of casual contact. Being clear about the time-limited nature of therapy also can motivate a resident to take advantage of the time she has with you.

We do not mean that it is necessary (or beneficial) to tell a resident the exact number of sessions for which you will be meeting. Indeed, with residents who are reluctant to engage in the therapeutic process you may introduce the topic later—perhaps not even at the first session—and less definitively so that you avoid

discouraging their participation. Overemphasizing the limited nature of the treatment may provoke some residents to disengage from the therapy even before it has begun. Their thought, whether verbalized or not, may be, “Why should I bother confiding in this person when she is eventually going to leave me anyway?” On the other hand, with residents who are more dependent you may have a sense that it is important to address termination earlier in the course of therapy and with more determination.

Below are two examples of how you might introduce the idea that treatment is time-limited. The first approach might be more appropriate for residents with more intact cognition. The second approach might be more appropriate for residents with more significant cognitive impairment, residents who have less experience with psychotherapy, or residents who are reluctant to begin therapy.

Example #1

“The treatment we’re going to start together usually lasts for about eight weeks. We’ll meet two times a week at first, for 20-30 minutes at a time, and less often over the course of our time working together. In total we’ll meet for about 16 sessions. Meeting for this amount of time seems to be helpful for people who are depressed. Many people see improvement in how they are feeling by the end of 16 meetings, although you may feel better even after a few meetings. It’s important to keep in mind, though, that you and I will be meeting for only a few weeks, and we want to make sure we make the most of our time together.”

Example #2

“You and I will be meeting for some short visits a couple times each week for a few weeks. I want to take time to get to know you and give you a chance to get to know me. During our meetings we’ll talk about things that are important to you and how we might help you feel better. Most people feel better after talking with someone, and I expect you’ll feel better after a few meetings. In a few weeks we’ll take a look at how you’re doing and see how many more meetings we want to have.”

Notice that in the second introduction there is no explicit mention of termination. Instead, the eventual end of therapy is something you may choose to bring up in the

second session or at least by the third session, once the therapeutic alliance is more firmly established.

As the final session approaches, the amount of time you spend talking about the end of therapy will naturally increase. When only 2-3 sessions remain it is a good idea to discuss the exact number of meetings left and the exact date of your final session. Again, residents with moderate cognitive impairment may need even more frequent reinforcement of time limits or tangible reminders.

You may encounter some residents who respond to the mention of termination with glib but pessimistic anticipation: “Oh, 16 meetings, I’ll be lucky if I’m around that long.” Or they may flinch at the idea of meeting for consecutive weeks by saying, “I don’t think I’ll need that many meetings. I’m not that bad off.” Be aware of the potential for unspoken meaning beneath these kinds of comments (e.g., a concern about mortality, discomfort with the prospect of establishing a relationship that is destined to end, a minimization of distress, or a reluctance to be a burden to anyone by engaging in the “selfish” task of talking about oneself).

When you bring up the mechanics of termination you’ll also want to address a resident’s feelings about termination. You can gain valuable information by paying attention to how a resident reacts to this topic as well as by what she says. A resident who negates the impact of termination, claims to have no feelings about the end of therapy, or discounts the impact of the therapeutic relationship despite successful gains may be resorting to a protective defensiveness. On the other hand, some residents may have a wholly practical attitude in which they express their gratitude in unsentimental ways and get on with their life.

What to do during the last session

During the final session you will want to talk directly about how the resident feels about the end of therapy. She may express sadness about losing contact with you. She may be concerned about her ability to cope on her own without the buffer of your sessions. She also may have anxiety about her ability to manage future recurrences of depression.

You can allay some of those concerns by reviewing the course of therapy, progress the resident has made, and her current status in accomplishing the treatment goals. You might tell the resident, “We’ve been meeting for about three months now, and you have made some important changes in your life. When we first started talking you were reluctant to eat your meals in the dining room but now you are going regularly and you seem to enjoy the company. I also remember that you were feeling like you didn’t have much reason to go on living. But now I hear you talk about looking forward to visits from your son and to visiting with your friends down the hall. These are all signs that your depression is better, and you made an impressive effort to get better. I’ve really enjoyed working with you, and I wish you continued good health and happiness.” The final session also may be a time when the resident can talk about additional things she wants to accomplish on her own now that she has gained skills from the therapy.

At this point, if not sooner, it also is important to review relapse prevention strategies. You may be able to minimize the severity and duration of the resident's future distress by preparing her for the return of depressive symptoms, and by encouraging her to be sensitive to early warning signs and to seek help before the symptoms escalate in severity. Relapse prevention efforts also may include an explicit review of the mobilization supports you and the resident have put into place. It may be helpful for you to construct a "survival guide" for the resident that can be left with her. In that written document you could outline her treatment progress and include warning signs for relapse and resident-initiated interventions (e.g., lists of pleasurable activities, staff to talk with).

Throughout your discussions of termination it is important to distinguish the friendly contact you may have with the resident after ending therapy from your therapeutic sessions. You can tell the resident that she probably will see you in the hallway from time to time, and that you will check in on her to say hello and see how she is doing, but these friendly visits will be different from your therapeutic sessions; the personal and private conversations you had during therapy will not be part of your future interactions. Individuals with significant cognitive impairment may have even greater difficulty distinguishing the casual contact you will have with them from your formal meetings. Be prepared to set clear limits ahead of time.

Finally, you may want to discuss your own feelings regarding termination and your perspective on your work together. If you have not previously shared much information about yourself with the resident, this can be an opportunity to demystify your status as the therapist. Self-disclosure also can reinforce the positive aspects of being in a relationship, positive aspects that can continue even after routine contact subsides. When termination is unusually difficult for the resident or uncommonly difficult for you, it may be appropriate to seek outside supervision to help you navigate the termination process. For instance, strong countertransference feelings based on your own family of origin may complicate your ability to separate from a resident. Likewise, you may find yourself reluctant to end therapy with a resident with whom you have established a close and meaningful working relationship. Conversely, a therapy that has been relatively "unsuccessful" may evoke feelings of professional failure that you may want to talk about with another professional. Supervision can help you work through these thoughts.

A word about gifts

Some residents may offer you a gift at the end of therapy. Should you accept the gift or politely decline? There are no strict rules on this issue, but there are clinical and ethical considerations to keep in mind. For instance, a gift of cash is unallowable. You are being compensated for your work through other channels, and accepting money directly from the resident is clearly unethical. The financial value of a material possession is another consideration. A hand-painted craft might not seem unreasonable, but a family heirloom necklace would likely be excessive. The clinical significance of the gift also might influence your actions. A gift motivated by sincere gratitude may be an important element in a successful termination, while a gift whose intention is to obligate you to continued contact with the resident or future “favors” should be avoided.

In our experience accepting a gift can be an important way of enabling the resident to give something back to you when she feels genuinely thankful for your efforts. Cultural and cohort influences may propel the resident to give you a token of her appreciation. Refusing a gift, in turn, may be perceived as an insult. As with other aspects of psychotherapy, consider carefully the meaning of the gift, the meaning of its being given, and the impact of its acceptance (or polite refusal).

What to do after the last session

Some follow-up activities after your last session can help solidify treatment gains to make certain they are maintained.

- Share a treatment summary with the resident

It may be helpful to review with the resident both verbally and in written form her original goals, the progress she has made and skills she has learned in treatment, potential stressful events she may encounter in the future, warning signs for relapse, and steps she can take if these signs emerge. As a “survival guide,” this discussion and corresponding document can remind the resident of interventions she can initiate to ward off a return of depressive symptoms. It might include a list of pleasurable activities, professional or personal contacts to talk with, and other supports and referral options (e.g., adult day care, therapeutic workshop).

- Share a treatment summary with the staff

Both written and verbal reports about the resident's progress and functioning will remind the staff that you are no longer following the resident. You can reiterate the mobilization efforts that rely on future staff participation. This is also an opportunity to thank the staff for their assistance and provide positive feedback for their help.

Sample termination feedback form for staff

Resident: Emma Clarke

Therapist: Pat Parker Date therapy ended: 4/24

Mrs. Clarke was seen for 14 sessions of psychotherapy to address her depression. She made excellent progress, is feeling much happier, and has returned to her previous level of activity and engagement on the unit. Candace Smith, a nursing assistant on the unit, was an active participant in Mrs. Clarke's treatment who encouraged her to get involved in pleasurable activities. Candace knows Mrs. Clarke well, is familiar with how depression appears in her, and knows what interventions are most helpful.

Possible signs of relapse to watch for:

- 1) She spends more time in her room than usual.
- 2) She becomes more short-tempered and irritable.
- 3) She refuses visits or phone calls from family.

Actions staff can take:

- 1) Remind Mrs. Clarke about the signs of depression.
- 2) Encourage participation in unit activities.
- 3) Encourage participation in other activities she enjoys (see the list of activities Mrs. Clarke has; this list is also in her chart)
- 4) Request a consultation for psychological evaluation if symptoms continue

- Provide the family information about potential recurrence of depressive symptoms

You may be able to prepare them to identify future deterioration in mood before

it becomes severe.

- Check in with the resident periodically

This may involve informal visits with the resident and staff to see whether Mobilize initiatives you put into place are still being followed. These brief check-ups can be used to monitor mood as well. If a resident's mental health deteriorates immediately after termination, you might consider a referral to a counselor or friendly visitor who can provide continued support in a less structured format.

Interactions with the resident in which you gain important information about their functioning may be worth documenting in their chart. Note that these informal visits may or may not be billable, depending on the practices of the organization where you work.

- Let the resident, staff, and family know that re-referral is possible if symptoms reappear

If the resident experiences a relapse in depression she can be referred again for evaluation and treatment. Make certain that the resident, family members, and staff are aware that you might be available to see the resident in the future if her mental health deteriorates.

The circumstances of termination

So far we have discussed termination as part of the natural progression of a psychotherapeutic encounter. When you are working with residents in long-term care facilities, however, termination isn't always so orderly. There are a variety of circumstances in which termination occurs, each of which comes with its own set of issues.

- Termination at the end of *successful* therapy

This type of ending is relatively straightforward, and all the issues highlighted above deserve consideration.

- Termination at the end of *unsuccessful* therapy

On occasion you will work with a resident for whom the therapy is not beneficial. Knowing when to stop therapy is a matter of good clinical judgment. Sometimes residents may themselves decide that they no longer wish to continue seeing you. Termination in this situation might involve an open acknowledgment of the difficulties in therapy and a discussion of transfer to another therapist or other treatment options, when appropriate. For instance, you might consider referral for a psychiatric evaluation

and the possibility of antidepressant medications or ETC. A polite, cordial end to therapy is the best resolution in this circumstance.

- Termination due to physical or cognitive incapacity

You may be working with a resident for a number of weeks, and then return to work on a Monday and find that over the weekend she had a stroke and is no longer able to talk. Or, during the course of therapy, dementia may progress to the point where the resident is no longer able to maintain any focus in session. Unexpected changes in physical or cognitive status can come at any time and can change the goals you might have for the resident. In these situations you'll need to consider what is in the best interest of the resident and, when necessary, how to terminate in a way that is as sensitive and useful as possible to the resident. A final, brief session may be all that is possible. Or, if the resident's condition is expected to improve, you may simply postpone therapy and let the resident know you will resume when her health has improved.

- Termination due to death

Whether anticipated or unanticipated, the death of a resident can leave a therapist in an awkward situation. First, you may have strong feelings about the loss of the resident that are important to acknowledge. A more practical issue is whether to attend funeral services. You need to keep confidentiality in mind when thinking about attending services both inside and outside the residence. In any case, this situation can be unsettling, and therapists need to be aware of their own feelings in this unfortunate but not uncommon circumstance.

Final thoughts about REM

Psychotherapy is a complex process no matter what the focus, setting, or technique. Each client brings a new set of issues and needs, and even with the same client those issues and needs vary from session to session. In this manual we've tried to present a general framework for working in a long-term care residence with individuals with dementia and depression. The complexity of psychotherapy is as great for these clients as for any others. By building on clients' strengths and attending to systems issues, REM attempts to help clients maximize resources both internal and external. Above all, throughout the treatment, flexibility is essential—flexibility in technique, style, and goals. We hope the REM manual refutes the common misconception that treatment manuals are rigid in their directives about what to do and when to do it. The three phases of treatment, and the goals within each phase, are fluid and meant to be

responsive to the needs of your clients and the resources of the residence in which you work. We acknowledge that this is challenging, but it also is rewarding work that can contribute to the quality of life for long-term care residents.

Appendix ~ Additional Resources

In recent years a number of excellent resources have appeared that address psychotherapy with older adults. Here we provide a brief list of some of the resources that have been influential in our work. Some of these references are designed for a variety of practitioners who might work with older adults (e.g., American Psychological Association, 1997; Gastel, 1994), while others address more specific topics such as psychotherapy with older adults (e.g., Knight, 1996) and mental health in long-term care (e.g., Molinari, 2000).

This list is somewhat arbitrary, a product of what we've come across and what's resonated with us. Apologies to anyone whose work was inadvertently left out due to the limits of our own knowledge. We welcome hearing from others who are aware of additional resources that might inform this work.

Selected publications

American Psychological Association (1997). *What practitioners should know about working with older adults*. Washington, DC: Author.

A brochure for all types of practitioners. Addresses commonly held myths about older adults, enumerates the common problems (including psychological) faced by older adults, and addresses assessment and intervention, including modifications that may be important to make for this group. Also available on-line at www.apa.org/pi/aging/practitioners.pdf.

Bell, V., & Troxel, D. (1997). *The best friends approach to Alzheimer's care*. Baltimore, MD: Health Professions Press.

This volume is enthusiastic about the potential for improving the quality of life for people with dementia using a simple approach that acknowledges remaining strengths and vitality. The authors encourage a "best friends" (just as it sounds, friendly, casual, compassionate) approach to dementia care in their discussion of communication, activities, and long-term care, among other topics.

Duffy, M. (Ed.) (1999). *Handbook of counseling and psychotherapy with older adults*. New York: John Wiley & Sons, Inc.

A broad resource with chapters that cover process issues in psychotherapy with older adults, group and expressive therapies, family and intergenerational

approaches, social and community interventions, and treatment approaches for a wide range of specific disorders.

Knight, B. G. (1996). *Psychotherapy with older adults* (2nd ed.). Thousand Oaks, CA: Sage.

One of the classic texts in the area. Introduces what Knight calls a Contextual, Cohort-Based Maturity/Specific Challenge Model for psychotherapy with older adults. Additional chapters cover building rapport, transference and countertransference, assessment, grief work, the impact of chronic illness on treatment, and life review. An excellent merging of research and clinical wisdom.

Gastel, B. (1994). *Working with your older patient: A clinician's handbook*. Bethesda, MD: National Institute on Aging, National Institutes of Health.

Intended mainly for physicians and nurses, this introductory guide emphasizes the importance of taking the older patient's perspective. Also addresses possible communication barriers, how to explore sensitive topics, providing education to the patient, and ways to involve family members.

Hersen, M., & Van Hasselt, V. B. (Eds.). (1996). *Psychological treatment of older adults: An introductory text*. New York: Plenum Press.

Reviews a variety of specific disorders and problems and treatments appropriate for older adults. Also includes a chapter by Burgio, Cotter, & Stevens on treatment in residential settings which focuses on nonpharmacological therapies used to treat disruptive behaviors.

Karel, M. J., Ogland-Hand, S., Gatz, M., & Unuetzer, J. (2002). *Assessing and treating late-life depression: A casebook and resource guide*. New York: Basic Books.

Uses a series of cases to discuss different treatment approaches for depression in older adults. It includes a chapter on comorbid dementia and depression, and the other chapters collectively describe many of the principles interwoven in REM therapy.

Lichtenberg, P. A. (1994). *A guide to psychological practice in geriatric long-term care*. New York: Haworth Press.

Along with a chapter on some of the practical applications of psychotherapy in long-term care, this volume includes others that address working with paraprofessionals and interdisciplinary teams.

Molinari, V. (Ed.) (2000). *Professional psychology in long term care*. New York: Hatherleigh Press.

A comprehensive edited volume that addresses assessment issues among long-term care residents and then an extensive coverage of treatment options. Chapters focus on individual, family, and group therapies, with additional attention paid to enhancing quality of life, counseling the dying patient, and working with multidisciplinary teams. Some of the professional issues that are addressed include ethics, clinical research, and public policy.

Norris, M. P., Molinari, V., & Ogland-Hand, S. (Eds.) (2002). *Emerging trends in psychological practice in long-term care*. New York: The Haworth Press.

Sections in this edited volume cover modifications of traditional psychotherapy techniques (e.g., group therapy, using positive core memories, behavior management) and multidisciplinary and systemic issues (e.g., family work, behavioral intervention using pleasant events, resident versus staff perceptions).

Zarit, S. H., & Knight, B. G. (Eds.). (1996). *A guide to psychotherapy and aging*. Washington, DC: American Psychological Association Press.

This volume examines effective clinical interventions for older adults, with chapters that review research findings regarding a range of intervention approaches. Cognitive-behavioral, interpersonal, and psychodynamic approaches are addressed, as are family therapy and caregiver-based interventions. Additional chapters examine assessment techniques, acknowledging the role of medical conditions in intervention, and ethical considerations. Also includes a chapter by Spayd and Smyer on interventions in nursing homes.

Selected web resources

Psychologists in Long Term Care	www.wvu.edu/~pltc
American Psychological Association Division 20 (Adult Development & Aging)	http://aging.ufl.edu/apadiv20/apadiv20.htm
American Psychological Association Division 12, Section II (Clinical Geropsychology)	http://bama.ua.edu/~appgero/apa12_2
American Association for Geriatric Psychiatry	http://www.aagppa.org/
National Association of Social Workers	http://www.socialworkers.org/practice/aging/default.asp
American Society on Aging	www.asaging.org
Gerontological Society of America	www.geron.org

References

- Alexopoulos, G. S., Abrams, R. C., Young, R. C., & Shamoian, C. A. (1988). Cornell Scale for Depression in Dementia. *Biological Psychiatry*, 23, 271-284.
- American Psychological Association. (1992). *Ethical principles of psychologists and code of conduct*. Washington, DC: American Psychological Association.
- American Psychological Association (1997). *What practitioners should know about working with older adults*. Washington, DC: Author.
- Baltes, M. M. (1988). The etiology and maintenance of dependency in the elderly: Three phases of operant research. *Behavior Therapy*, 19, 301-319.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 44, 53-62.
- Borson, S., & Fletcher, P. M. (1996). Mood disorders. In W. E. Reichman & P. R. Katz (Eds.), *Psychiatric care in the nursing home* (pp. 67-93). Oxford: Oxford University Press.
- Caron, W. A. (1997). Family systems and nursing home systems: An ecosystemic perspective for the systems practitioner. In T. D. Hargrave & S. M. Hanna (Eds.), *The aging family: New visions in theory, practice, and reality* (pp. 235-258). Philadelphia: Brunner/Mazel, Inc.
- Carpenter, B., Ruckdeschel, K., Ruckdeschel, H., & Van Haitsma, K. (2002). R-E-M psychotherapy: A manualized approach for long-term care residents with depression and dementia. *Clinical Gerontologist*, 25, 25-50.
- Cohen-Mansfield, J., Marx, M. S., & Rosenthal, A. S. (1989). A description of agitation in a nursing home. *Journals of Gerontology: Medical Sciences*, 44, M77-M84.
- Cotrell, V., & Schulz, R. (1993). The perspective of the patient with Alzheimer's disease: A neglected dimension of dementia research. *The Gerontologist*, 33, 205-211.
- Cruse, R. (2000). The impact of culture and gender on mental health. In V. Molinari (Ed.), *Professional psychology in long term care* (pp. 373-400). New York: Hatherleigh Press.

- Department of Veterans Affairs. (1997). *Assessment of competency and capacity of the older adult: A practice guideline for psychologists*. Milwaukee, WI: National Center for Cost Containment. (Available in most VA libraries or from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA, 22161, (703) 487-4650.)
- Fellows, L. K. (1998). Competency and consent in dementia. *Journal of the American Geriatrics Society*, 46, 922-926.
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189-198.
- Frazer, D. W., & Jongsma, A. E. (1999). *The older adult psychotherapy treatment planner*. New York: John Wiley & Sons.
- Gastel, B. (1994). *Working with your older patient: A clinician's handbook*. Bethesda, MD: National Institute on Aging, National Institutes of Health.
- Gelfand, D. E. (1994). *Aging and ethnicity: Knowledge and services*. New York: Springer.
- Grunes, J. (1987). The aged in psychotherapy: Psychodynamic contribution to the treatment process. In J. Sadavoy, & M. Leszcz (Eds.), *Treating the elderly with psychotherapy: The scope for change in later life*. Madison, CT: International Universities Press.
- Hamilton, M. (1967). Development of a rating scale for primary depressive illness. *British Journal of Social and Clinical Psychology*, 6, 278-296.
- Helmes, E. (1988). Multidimensional Observation Scale for Elderly Subjects (MOSES). *Psychopharmacology Bulletin*, 24, 733-745.
- Hersen, M., & Van Hasselt, V. B. (Eds.). (1996). *Psychological treatment of older adults: An introductory text*. New York: Plenum Press.
- I.D.E.A.S. Inc., (1998). *REMODEL: Maximizing cognitive and functional abilities resource manual*. Cleveland, OH: I.D.E.A.S. Inc.
- Janoff-Bulman, R., & Marshall, G. (1982). Mortality, well-being, and control: A study of a population of institutionalized aged. *Personality and Social Psychology Bulletin*, 8, 691-698.

- Jongsma, A. E., & Peterson, L. M. (1995). *The complete psychotherapy treatment planner*. New York: John Wiley & Sons.
- Kahn, R. L., Goldfarb, A. I., Pollack, M., & Peck, A. (1960). Brief objective measures for the determination of mental status in the aged. *American Journal of Psychiatry*, *117*, 326-328.
- Karel, M. J., Ogland-Hand, S., Gatz, M., & Unuetzer, J. (2002). *Assessing and treating late-life depression: A casebook and resource guide*. New York: Basic Books.
- Kasl-Godley, J., & Gatz, M. (2000). Psychosocial intervention for individuals with dementia: An integration of theory, therapy, and a clinical understanding of dementia. *Clinical Psychology Review*, *20*, 755-782.
- Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A., & Jaffe, M. W. (1963). Studies of illness in the aged – The index of ADL: A standardized measure of biological and psychosocial function. *Journal of the American Medical Association*, *185*, 914-919.
- Kiresuk, T. J., & Sherman, R. E. (1968). Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal*, *4*, 443-453.
- Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy*. Pacific Grove, CA: Brooks/Cole.
- Kitwood, T. (1998). Toward a theory of dementia care: Ethics and interaction. *Journal of Clinical Ethics*, *9*, 23-34.
- Knight, B. G. (1996). *Psychotherapy with older adults* (2nd ed.). Thousand Oaks, CA: Sage.
- Koenig, H. G. (1994). *Aging and God: Spiritual pathways to mental health in midlife and later years*. NY: Haworth Press.
- Koocher, G. P., & Keith-Spiegel, P. C. (1998). *Ethics in psychology: Professional standards and cases* (2nd ed.). New York: Oxford University Press.
- Kovel, J. (1976). *A complete guide to therapy*. New York: Pantheon Books.
- La Rue, A. (1992). *Aging and neuropsychological assessment*. New York: Plenum Press.
- Lawton, M.P. (1988). Scales to measure competence in everyday activities. *Psychopharmacology Bulletin*, *24*, 609-614.

- Lawton, M. P. (Ed.). (1994). *Annual review of gerontology and geriatrics* (Vol. 14). New York: Springer.
- Lawton, M. P., & Brody, E. M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9, 179-186.
- Lawton, M. P., Van Haitsma, K., Klapper, J., Kleban, M., Katz, I., & Corn, J. (1998). A stimulation-retreat special care unit for elders with dementing illness. *International Psychogeriatrics*, 10, 379-395..
- Lewis, M. M. (2001). Spirituality, counseling, and elderly: An introduction to the spiritual life review. *Journal of Adult Development*, 8, 231-240.
- Lichtenberg, P. A. (Ed.). (1999). *Handbook of assessment in clinical gerontology*. New York: John Wiley & Sons.
- Logsdon, R. G., & Teri, L. (1997). The Pleasant Events Schedule-AD: Psychometric properties and relationship to depression and cognition in Alzheimer's disease patients. *The Gerontologist*, 37, 40-45.
- McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: William Morrow.
- Mattis, S. (1973). *Dementia rating scale*. Odessa, FL: Psychological Assessment Resources, Inc.
- Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behavioral Research and Therapy*, 28, 487-495.
- Molinari, V. (Ed.) (2000). *Professional psychology in long term care: A comprehensive guide*. New York: Hatherleigh Press.
- Ogland-Hand, S. M., & Zeiss, A. M. (2000). Interprofessional health care teams. In Molinari, V. (Ed), *Professional psychology in long term care: A comprehensive guide* (pp. 257-277). New York: Hatherleigh Press.
- Perlmutter, L. C., & Eads, A. S. (1998). Control: Cognitive and motivational implications. In J. Lomranz (Ed.), *Handbook of aging and mental health: An integrative approach* (pp. 45-67). New York: Plenum.

- Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatrics Society*, 23, 433-441.
- Pillemer, K., Hegeman, C. R., Albright, B., & Henderson, C. (1998). Building bridges between families and nursing home staff: The Partners in Caregiving program. *The Gerontologist*, 38, 499-503.
- Pope, K. S., & Vasquez, M. J., T. (1998). *Ethics in psychotherapy and counseling: A practical guide*. San Francisco: Jossey-Bass.
- Port, C. L., Gruber-Baldini, A. L., Burton, L., Baumgarten, M., Hebel, J. R., Zimmerman, S. I., & Magaziner, J. (2001). Resident contact with family and friends following nursing home admission. *The Gerontologist*, 41, 589-596.
- Pruchno, R. A., Smyer, M. A., Rose, M. S., Hartman-Stein, P. E., & Henderson-Laribee, D. L. (1995). Competence of long-term care residents to participate in decisions about their medical care: A brief, objective assessment. *The Gerontologist*, 35, 622-629.
- Rader, J. (1995). Assessing the external environment. In J. Rader, & E. M. Tornquist (Eds.), *Individualized dementia care: Creative, compassionate approaches* (pp. 47-82). New York: Springer.
- Rockwood, K., Stolee, P., Howard, K., & Mallery, L. (1996). Use of goal attainment scaling to measure treatment effects in an anti-dementia drug trial. *Neuroepidemiology*, 15, 330-338.
- Rodin, J., & Langer, E. J. (1977). Long-term effects of control-relevant intervention with the institutionalized aged. *Journal of Personality and Social Psychology*, 35, 897-902.
- Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University.
- Rosenberg, M. (1979). *Conceiving the self*. New York: Basic Books.
- Sherrill, J. T., Frank, E., Geary, M., & Stack, J. A. (1997). Psychoeducational workshops for elderly patients with recurrent major depression and their families. *Psychiatric Services*, 48, 76-81.
- Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the STAI*. Palo Alto, CA: Consulting Psychologists Press.

- Storandt, M., & VandenBos, G. R. (Eds.). (1994). *Neuropsychological assessment of dementia and depression in older adults: A clinician's guide*. Washington, DC: American Psychological Association Press.
- Sunderland, T., Alterman, I. S., Yount, D., Hill, J. L., Tariot, P. N., Newhouse, P. A., Mueller, E. A., Mellow, A. M., & Cohen, R. M. (1988). A new scale for the assessment of depressed mood in demented patients. *American Journal of Psychiatry*, *145*, 955-959.
- Teri, L. (1994). Behavioral treatment of depression in patients with dementia. *Alzheimer's Disease and Associated Disorders*, *8*, 66-74.
- Teri, L. & Gallagher-Thompson, D. (1991). Cognitive-behavioral interventions for treatment of depression in Alzheimer's patients. *The Gerontologist*, *31*, 413-416.
- Teri, L., Logsdon, R. G., Uomoto, J., & McCurry, S. M. (1997). Behavioral treatment of depression in dementia patients: A controlled clinical trial. *Journals of Gerontology: Psychological Sciences*, *52B*, P159-P166.
- Tobin, S. S. (1999). *Preservation of the self in the oldest years: With implications for practice*. New York: Springer.
- Valle, R. (1998). *Caregiving across cultures: Working with dementing illness and ethnically diverse populations*. Washington, DC: Taylor & Francis.
- Vittoria, A. K. (1998). Preserving selves: Identity work and dementia. *Research on Aging*, *20*, 91-136.
- Walitzer, K. S., Dermen, K. H., & Connors, G. J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification*, *23*, 129-151.
- Wilson, D. O. (1985). The effects of systematic client preparation, severity, and treatment setting on dropout rate in short-term psychotherapy. *Journal of Social and Clinical Psychology*, *3*, 62-70.
- Yesavage, J., Brink, T., Rose, T., Lum, O., Huang, O., Adey, V., & Leirer, V. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research*, *17*, 37-49.
- Zarit, S. H., & Knight, B. G. (Eds.). (1996). *A guide to psychotherapy and aging*. Washington, DC: American Psychological Association Press.

Zeiss, A. M., & Steffen, Ann M. (1996). Interdisciplinary health care teams: The basic unit of geriatric care. In Carstensen, L. L., & Edelstein B. A. (Eds.), *The practical handbook of clinical gerontology* (pp. 423-450). Thousand Oaks, CA: Sage Publications, Inc.

Zwick, R., & Attkisson, C. C. (1985). Effectiveness of a client pretherapy orientation videotape. *Journal of Counseling Psychology*, 32, 514-524.

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